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Factors Influencing Grief Adjustment in the Elderly

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FACTORS INFLUENCING GRIEF ADJUSTMENT IN THE ELDERLY

by

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This work is dedicated with love to Lorraine Mangan Johnson, my mother, to my grandmothers, Eva Alley and Madeline Reidy, and to all my great-grandmothers with whom I am acquainted only through family legend. I was the first of us to pursue a college education to completion, the first to have opportunity to do so. Their work and lives are always with me in memory, and encourage me onward.

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ABSTRACT

Factors Influencing Grief Adjustment

in the Elderly

by

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The purpose of this paper was to attempt to identify variables which may enhance the ability of older widowed persons to adjust to bereavement. Depression and perceptions of physical health were the two aspects of adjustment selected for study. Several variables which current literature suggests may mediate grief adjustment were examined for their potential relationship to bereavement outcome. These were gender, level of grief, anticipatory grief and social network. The possible relationship between depression and perceptions of physical health was also examined for.

Subjects were 75 men and women, age 55 and over, who were recently widowed, and 29 non-bereaved men and women who served as controls. All subjects were Caucasian, Mormon, and lived in small rural communities. To gather data on the variables in question, these instruments were

used: the Beck Depression Inventory, and the Texas Inventory of Grief. Information on anticipatory grief, social network, and self-ratings of physical health was obtained using a structured interview developed at the Andrus Gerontology Center at the University of Southern California. Data was gathered at two times. The initial interview was held within two months of the death of each bereaved subject's spouse, and again six months later. Control subjects were interviewed twice, six to eight months apart.

Multiple regression equations with foreward inclusion were computed to identify those variables which accounted for most of the covariance in depression scores and self-ratings of physical health.

Gender and bereavement status (whether a subject was bereaved or control) were not found to be significantly related to depression or self-ratings of physical health. Social network variables were found to facilitate lower depression scores and higher ratings of physical health, although the aspects of social network which were significant varied over time (initially family, then later non-family relationships were most important.) Depression and self-ratings of physical health were closely related. High level of grief was closely associated with high depression scores, but not with self-ratings of physical health. Expectation of the spouse's death was associated with lower self-ratings of physical health.

(93 pages)

CHAPTER I

INTRODUCTION

The death of a spouse is consistently seen as a major life stressor requiring a particularly large amount of readjustment. It has been found to be associated with increases in physical and mental health problems, increased mortality, and disruption of many aspects of a survivor's pattern of living. This finding has been replicated by researchers using subjects of varying ages and diverse cultural backgrounds (Holmes & Masuda, 1970). Holmes and Rahe (1967) concluded that spousal loss is commonly perceived as the most stressful normally occuring event an individual may have to recover from, based on the responses of 394 subjects who took the Social Readjustment Scale. On this paper and pencil test, subjects were asked to rate 43 stressful events as more or less stressful by ascribing some value to each (using "Marriage" as a arbitrary guide at 500 points in value.) Death of a spouse was rated overall as the most stressful item of the 43. Calling conjugal bereavement an important health problem, Jacobs and Ostfeld (1977) reviewed the epidemiological literature and found excess mortality among the newly widowed, particularly among younger persons and men across all age groups. Young, Benjamin and Wallis (1963), in examining the mortality rates of 4,486 widowers, aged 55 and over, found a 40% increase in deaths during the first six months of bereavement; afterwards the rate returned to that of married men. In their study of the characteristics of the elderly in three industrial

societies (Denmark, Britain and the U.S.), Shanas, Townsend, Wedderburn, Friis, Miljh, and Stehouwer (1968) administered structured interviews to approximately 2,500 older persons in each country. Across all three cultures they found loneliness to be more significantly a problem for the widowed and divorced than it was among the same aged persons whose marraiges were intact. Widows who had no children reported more loneliness than any other group. Referring to loneliness as a wish for a level or form of intimacy which one is not experiencing, Lopata (1969) pointed out some of the forms the loneliness of the newly widowed may take: loneliness for the spouse as an individual, love object, companion, lover, organizer of time and work, and source of status and lifestyle. Loss of a spouse appears to affect almost every aspect of the survivor's life.

Widowed persons appear to experience multiple problems, with a number of social-psychological variables combining to modify the impact of the widowhood experience for each individual. As has been mentioned above, increased physical health problems and higher mortality risk seem to be common after effects of conjugal bereavement, at least for certain subgroups of the widowed (Marris, 1951, Parkes & Brown,1972). Mental health problems, and in particular depression, are also cited frequently in the literature as common problems among the bereaved, the former being most often seen among younger widows (Clayton, 1979).

Many variables have been suggested and explored to some extent for their possible mediating effects on the physical and mental health problems evidenced by the recently widowed. These include religious

philosophy and activity (Berardo, 1967), prior relationship with the deceased spouse (Gallagher & Thompson, 1981), income (Parkes, 1975), personality traits of the survivor (Gerber, Rusalem, Hannon, Battin, & Arkin, 1975), the cumulative effect of all the various stressors occuring in the bereaved person's life at one time (Gallagher & Thompson, 1981), and the person's age and gender (Stroebe & Stroebe, 1983). Two sources of mediating variables that have been most strongly suggested as related to bereavement outcome are the characteristics of the social support experienced by the survivor, and the manner in which he or she adjusts to the loss through grieving (Mitchell & Trickett, 1980; Lindemann, 1944). Anticipatory grieving, whether the survivor had some forewarning of the impending death, thereby having opportunity to begin the grief and adjustment process in advance, has been suggested by Gerber et al. (1975) as being a strong mediating variable.

Problem Statement

The stress of widowhood and the adjustment it requires for the survivor is well documented. A need exists to develop a clearer understanding of how environmental and personal variables impact the widowed person's ability to adjust to these changes in a positive way. The physical and mental health needs of the increasing proportion of our population which has suffered the particular stress of spousal bereavement may be better served when is is understood more fully how different mediating variables serve to support or hamper healthier

adjustment.

Limitations

Since the sample studied was limited to elderly individuals willing to participate (resulting in a non-random sampling of the population), the data derived is subject to bias in that characteristics of elderly volunteers are over-represented. Unfortunately, the data base on characteristics of older volunteers is too meager at this time to allow reliable prediction of the amount and direction in which results may be biased by such overinclusion. Rosenthal and Rosnow (1976), in their review of the literature on volunteer subjects, listed 5 characteristics of volunteers which they judged as "warranting maximum confidence": volunteers tend to be better educated, of higher social class, more sociable, higher in need of social approval, and in general more intelligent. However, of the over 600 studies reviewed by Rosenthal and Rosnow, only a small portion had included elderly individuals in their subject pool. None of the studies attempted an overall assessment of characteristics reliably found in elderly volunteers. It seems likely that there are factors such as ill health, or less previous exposure to the concept of research which have significant impact on older persons' decisions to volunteer and which are less likely to influence young college students. The latter made up the bulk of the subject populations in the studies reviewed by Rosenthal and Rosnow. Since the breadth of information needed in this study was not obtainable from non-volunteers, and because of the value

of obtaining information from this unique subject pool (elderly, rural men and women of a single fundamentalist religious denomination, i.e. Mormon), the findings from this study are considered to be a valuable addition to the existing data on the experiences of the elderly bereaved.

Definitions

Throughout this manuscript the following terms will be used as defined below:

Bereavement. Unless otherwise indicated this term refers to general conjugal bereavement, the loss of a spouse.

Bereavement status. This indicates whether or not an individual was currently experiencing the particular stress of widowhood. For the purpose of this study, persons who had not become widowed within the previous five years were considered to be non-bereaved.

Social Network. For this study, social network was defined as the number of related and non-related persons each participant listed as important in his or her life now, the frequency of contact had with each listed person, and degree of positive or negative feelings had toward each. Frequency of contact was coded on a 1 to 7 scale, with 1 being "less than every two to three months", and 7 being "every day." Feelings were coded on a 1 to 7 scale, with 1 being "very negative", 4 being "mainly neutral", and 7 being "very positive".

Grief. Grief has been called "the constellation of signs and symptoms [that occur] following a significant personal loss" (Zisook & DeVaul, 1983, p. 247). In this paper, the level of grief an individual

was experiencing at a given time was defined as his or her score on the Texas Inventory of Grief "Present Feelings" scale (Faschingbauer, DeVaul & Zisook, 1977).

Depression. In this study depression was defined as scores on the Beck Depression Inventory (Beck & Beamsderfer, 1974).

Anticipatory Grieving. This refers to the psychological preparation for the impending death of a spouse which has been postulated to occur when an individual is aware that a loved one will soon die (Gerber et al, 1975). In this study, the opportunity for anticipatory grieving was defined as whether a subject had expected the death of his or her spouse, and the length of the late spouse's last illness.

This research project will be presented in the following four chapters. These chapters will include a review of the relevant literature, a presentation of the research methodology, the results, and a discussion of the results.

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

There are over 700,000 newly-widowed persons in the United States each year (Glick, Weiss & Parks, 1974). In 1960 there were 9 million widowed persons in this country (Balkwell, 1981). That number had increased by the time of the 1980 census to 12.5 million, of whom approximately 10.5 million were women (U.S.Census Bureau, 1982). Twenty-seven percent of these were 45-64 years old, with sixty-eight percent being aged 65 and over, with a median age of approximately 70. Three out of four American wives can expect to become widows at some point in their lives. The median age at which this occurs is 56 (Balkwell, 1981). These figures indicate that a substantial and increasing proportion of our population - mostly elderly, mostly women - have or will experience what has been called the most stressful of normal human events (Holmes & Rahe, 1967): the death of a spouse.

The sex ratio among widowed persons has changed greatly in recent years. In 1940 two out of three persons who'd lost a spouse to death were women; in 1968 the ratio was four to one; at present it approaches six to one (Balkwell, 1981; U.S. Census Bureau, 1982). Several factors have been cited as contributing to the growing magnitude of the widowed population, as well as its increasingly skewed sex ratio. These include differential mortality for men and women in successive age-cohorts, the difference in age at marriage between husbands and wives

(women usually being younger), and the lower rate of remarriage for widows in comparison to widowers (once widowed, women experience widowhood longer) (Balkwell, 1981; Berardo, 1967; Greenblatt, 1978), all of which combine to make widowhood a situation primarily faced by aged women. Lopata (1970), in her discussion of the social involvement of widows, concluded that most older men are married, while most older women are widows.

Although men as a group are not faced with the widowhood experience at the same rate or for the same duration as their female counterparts, their being underrepresented in research studies may lead to incomplete or distorted views of what the important antecedents are for better or worse adjustment to conjugal bereavement. There is some evidence that adaptation to widowhood may be more difficult for men, or at least present a somewhat different set of difficulties (Berardo, 1967,1970). Barrett (1978) in her comparison of 190 urban widowed persons (including 42 men) with married controls (mean age of subjects was 62), found that sex differences in her sample were most pronounced in psychosocial functioning and ability to meet nutritional and household needs, with males having the more frequent problems.

Although the literature in this area is diverse, conflicting findings makes it unclear at present which subgroups of widowed persons suffer most from the effects of spousal loss. Jacobs and Douglas (1979) concluded in their review that because men, the elderly, and ethnic minorities are poorly represented in the samples that have been

studied, present knowledge of adult grief is based largely on white women aged 65 and under. This bias in information is important to note because there is evidence that widowhood affects specific subgroups (young/old, male/female, etc.) in different ways. For example, sudden death of a spouse may be more stressful for younger widows than it is for older ones (Ball, 1977). This suggests that some of the conflicts in research findings are likely a result of the extent to which samples studied have excluded members of these subgroups.

The research to be discussed below suggests that for most people widowhood is accompanied by increased problems in the areas of mental and physical health. Some of the problem factors which have received discussion in the literature include gender, the characteristics of the person's social network, and whether or not he or she had any forewarning of the spouse's death (opportunity for anticipatory grieving). This review will be organized around these problem areas and mediating variables. The sequence begins with the effects of widowhood associated with mental and physical health, followed by sections on social networks, the process of grieving and anticipatory grief. The literature on gender differences will be presented within the appropriate sections.

Mental Health

The clinical literature contains numerous examples of mental health problems associated with widowhood (Balkwell, 1981; Clayton, 1974; Parkes, 1964, 1965, 1972). In a study of 22 widows under the age

of 65, Parkes (1972) found that within six months after the death of a relative, the number of persons admitted to an inpatient psychiatric unit for grief-related depression exceeded that which would have been expected by chance alone. Clayton's 1979 review, which included studies dealing with elderly subjects, showed that widows and widowers suffer from significant depressive symptoms in the first year of bereavement, and that psychiatric hospitalization (though infrequent) is most likely to take place early in the bereavement. Conroy (1977) described widows as being at high risk for mental illness because bereavement requires adaptation to major changes. In addition to the stress of loss, there may be changes in financial status (particularly for women), living conditions, personal habits, social activity, residence, and sleeping habits. The combination of such changes may exceed the ability of the average person to cope. These findings are consistent with those of Berardo (1970) who found significantly greater psychological distress in his widowed sample in comparison to married controls. In their study of the effects of bereavement on indicators of mental health in elderly widows and widowers, Gallagher, Breckenridge, Thompson, and Peterson (1983) compared data drawn from 199 persons two months after the deaths of their spouses with that of 79 non-bereaved elderly controls. Using scores from the Beck Depression Inventory, the Brief Symptom Inventory, and the Texas Inventory of Grief (Past and Present grieving scales), along with the subjects' ratings of their own mental health, the authors found that the bereaved group had significantly higher mean scores (showed greater distress) on all

measures. Although women scored significantly higher than men on the TIG Past scale, the BDI and the BSI, this sex difference was independent of bereavement status. The background variables of age, income, life occupation, education and number of years married were all significantly associated with mental health and grief scores, but only longevity was associated with a greater likelihood of depression.

Much of the literature in this area has focused on depression as the particular form of psychological disturbance most likely to be found among the bereaved. In her 1981 review Balkwell noted that "depression is so often experienced by the widowed that it may be viewed as a normal reaction to the loss of one's spouse" (p.119). Clayton and associates (Bornstein, Clayton, Halikas, Maurice & Robins, 1973; Clayton, Halikas & Maurice, 1971; and Clayton, 1974) administered structured interviews to a sample of 92 men and women first at 1 month, then at 16-20 months following the death of their spouse. They found that among their sample the presence of a clinical depression syndrome at one month was a powerful predictor of depression at one year, and concluded that depression is a common accompaniment of widowhood. When matched against a sample of married controls, widowed persons reported significantly more "psychological and physical depressive symptoms than their nonbereaved counterparts" (Clayton, 1974, p.747). The depressions triggered by grief did not occur with the same characteristics usually associated with clinical depression, however. Depression following the death of a spouse was not more common in women than men, was not associated with a family history of

depression or with previous depressive episodes, was not likely to be treated by psychiatrists, and was not associated with a subjective sense of being ill (Zisook & DeVaul, 1983).

In efforts to discover more precisely how depression is experienced by the bereaved, some researchers have examined it in terms of its affective and somatic components. As early as 1917, Freud observed important clinical differences between mourning and depression. He noted that while depressives and mourners reported the same affective symptoms (including loss of interest and enjoyment in customary activities, and feelings of emotional pain), mourners did not display the guilt and low self-esteem found in the depressives (Gallagher, Dessonville, Breckenridge, Thompson, and Amaral, 1981). Clayton, et al. (1971) compared their bereaved sample with a group of hospitalized depressives, and found significantly more guilt and suicidal thoughts in the latter, suggesting low self-regard. In order to further clarify the differing clinical pictures of depression versus grief, Gallagher et al. (1981) compared Beck Depression Inventory (BDI) scores for three groups of persons over the age of 55: 77 outpatients carrying the diagnosis of major depressive disorder, 77 persons who had suffered the death of a spouse within the previous two months, and 82 non-depressed, non-bereaved community residents who served as controls. The depressed individuals were found to score significantly higher on the BDI (mean score=24.25) than either the bereaved (mean score=9.61) or the controls (mean score=5.54), and the bereaved scored significantly higher than the controls. Bereaved persons differed from

the depressed by their infrequent endorsement of self-deprecatory items, while both groups differed from the controls on items expressing affective distress. The authors found that 80% of subjects could be correctly classified based on their responses to the BDI. They concluded that not only can the elderly bereaved experience depressive symptoms which do not necessarily indicate a clinically significant affective disorder, but that the BDI may be particularly useful to the clinician in discriminating between the two (Gallagher et al. 1981).

Berry, Storandt and Coyne (1984), replicating a similar study done using the Beck Depression Inventory, administered the Zung Self-Rating Depression Scale to 179 young adults (mean age=19.5) and 462 older adults (mean age=68) to determine if there were significant age-related differences in overall levels of depression, or in the number of somatic depressive symptoms reported. They found no age-related differences in the reporting of psychological symptoms of depression (feelings of sadness, isolation, etc.). Somatic symptoms, however, were significantly more likely to be reported by older women, though not by older men. The authors point out that the somatic complaints noted by the older women (greater difficulty sleeping at night, decreased interest in sex, loss of appetite, and increased constipation in comparison with younger women) are similar to the physical changes that often accompany aging, suggesting that "these potentially age-related somatic problems [should be explored] prior to attributing them to a depressive disorder, especially in older women" (p.467).

Regarding the issue of sex differences in the psychological impact

of partner-loss, Stroebe and Stroebe in their review (1983) stress the importance of including same sex control groups when designing research in this area. They state: "a sex main effect in the occurrence of depression has generally been observed...there appear to be no exceptions to the generalization that depression is more common in females than males" (p.283). Women are more likely to report depression, and to be perceived as depressed by health care professionals. This elevation in depression rate does not hold for all subgroups of women, however. While married women show higher rates of depression than do married men, the rates for single women are lower than those of single men. The state of being married seems to be correlated with better mental health for men but worse mental health for women (Balkwell, 1981; Stroebe & Stroebe, 1983),at least in terms of depression.

Any statements on whether males or females become more depressed in reaction to widowhood must take into account the higher base rate for women. An additional complication in comparing depression rates of widows and widowers may be the higher rate of alcohol abuse among men. It is possible that men are more likely to use alcohol to cope with grief and thus end up diagnosed as alcoholic rather than depressed: "depression may be the female equivalent of alcoholism in males as a reaction to events such as bereavement" (Stroebe & Stroebe, 1983, p.284).

In summary, the literature to date reveals a higher incidence of psychological distress and psychiatric problems reported among widowed

persons, both younger and older, than among non-widowed persons. Depression is the mental health problem most frequently reported after the death of a spouse. Although overall rates of depression are higher for women than for men, some evidence suggests that this difference may be related to marital status, and that the usual depression which results from grief may not occur with the same characteristics found with the depression of the non-bereaved. What sex differences may exist in the mental health problems suffered by the widowed is not yet clear.

The following section will present the literature on physical health as an additional area of functioning which may be impacted as a result of widowhood.

Physical Health

It has long been held true by health professionals that bereavement is a significant source of stress which has impact on the life and mortality of their patients (Thompson, Breckenridge, Gallagher, & Peterson, 1984). Engel's statement (in Fredrick, 1982-83) that grief seems to fulfill the requirements for a disease process is supported by the statistical study of Rees and Lutkins (1967), who found greatly increased mortality rates among bereaved individuals as compared to non-bereaved persons. In an exploration of precisely how the stresses of bereavement directly impact physical health, Fredrick (1982-83) reports that "the stress of acute grief brings about a rapid, reflexive release of ACTH (adrenocorticotropic hormone) by the pituitary...The

result of acute grief ...[resulting in] the suppression of the immune system" (p. 296). In view of this, it is not surprising that most of the literature confirms there is often a relationship between bereavement and changes in physical health.

As early as 35 years ago, Marris (1951) studied the relationship between widowhood and physical health by interviewing 72 London widows, on an average of two years after bereavement. Results (although rendered to be of questionable validity due to the length of time between bereavement and interview) showed that about one-half reported their health as being "poorer" than prior to bereavement. Parkes (1964) reviewed medical records of 44 London widows and found their consultations with their physicians doubled during the first six months of bereavement, with younger widows going for psychological complaints, and those 65 and older reporting physical symptoms. Confrey and Goldstein (1959) reviewed available data on health and age relationships, and concluded that in later life, health and marital status were significantly related: single persons (the majority of whom were widows) had more physical illnesses and higher mortality rates than married persons of the same age. Berardo (1967) found significantly greater incidence of health problems in widows aged 65 and over than in same-aged controls. He also found proportionately more health problems among widowers than widows.

A major prospective study of adaptation to bereavement was the "Harvard Project" (Parkes & Brown, 1972). In this study 68 widowed persons under the age of 45 (49 women, 19 men) were interviewed after

13 months of bereavement and again two to four years later. A number of indices of health and emotional disturbance were shown to distinguish the widows from a group of matched controls, especially increases in insomnia, use of alcohol and tranquilizers, and seeking help for emotional problems. A significant increase in physical symptoms was reported by men. but not women, in this study.

While the above findings are suggestive, they contain methodological weaknesses in that all data reported were obtained retrospectively and were based on varying constructs of good health which were not carefully distinguished from true physical illnesses, or from psychological symptoms.

A study done by Heyman and Gianturco (1973) is unusual both for its format and its results. Since they surveyed a sample of elderly people longitudinally for a number of years, some of whom became widowed over the course of the study, the researchers were able to obtain before and after data on their newly-bereaved subgroup. In sharp contrast to Berardo (1967) and others mentioned above, Heyman and Gianturco (1973) found that for both the men and women in their rural sample, widowhood had little or no adverse effect on evaluation of health status--there were no significant changes noted in health variables following widowhood. They attributed their unusual result to the advanced age of their subjects (all of their 41 subjects were over 65 years, and 33 were over 70) which they concluded resulted in well established social roles and a stable, placid lifestyle. They also hypothesized that the elderly are, by virtue of their life stage, well

aware of the possibility that they may outlive their spouse, and so are psychologically prepared in advance to expect and accept the role of widowhood. It seems likely, however, that other factors related to selection bias contributed to the study's outcome. These included higher than average income (most of the subjects were homeowners), and unusually well developed social networks which were not disrupted much by conjugal bereavement (subjects didn't move from original neighborhoods, and maintained active involvement in community and church groups). Also, since the average time elapsed between bereavement and interview contact was 21 months, it is possible that problems occurred but were resolved by the time of the interview and less likely to be noted than if subjects had been contacted sooner.

Valanis and Yeaworth (1982) used data drawn from a larger study of elderly bereaved persons aged 53 to 83 (N= 42 women, 18 men) to compare subjects own ratings of their physical and mental health with objective measures of the same. These objective measures consisted of the ratings given each subject by a nurse interviewer on the basis of a structured interview, the number of medications taken, and each person's score on the Zung Self-Rating Depression Scale. The authors found that their subjects tended to rate their own physical health significantly more positively than did the nurse-interviewers. This was particularly true of women. The nurses rated 65.6% of the under-70 age group as having fair or poor health, while only 37.5% of the subjects in this group rated themselves so. Of the over-70 group, 78.7% were rated as in fair or poor health by the interviewers, but

only 39.3% of the older subjects applied this rating to themselves. The authors suggested that this disparity may indicate that older people use negative stereotypes of "old people" as their comparison group when evaluating their own condition, and are more satisfied with their health when they perceive themselves as better off than they might have expected to be at their age. Differences between the subjects' self-ratings of their mental health and objective measures were not significant (Valanis & Yeaworth, 1982).

In support of the efficacy of elderly person's self-ratings of physical health, however, LaRue, Bank, Jarvik and Hetland (1979) found such ratings to be positively correlated with physicians' ratings of health status. The usefulness of such ratings is further supported by the findings of Mossey and Shapiro (1982) that perceived health can be used to significantly predict future mortality, even after age, socio-economic status and objective physical health factors have been controlled. Thompson, et al. (1984) studied the effects of conjugal loss on the self-perceptions of physical health of 212 recently bereaved elderly adults (113 women and 99 men) in comparison with that of 162 non-bereaved comparison controls. They found that although the bereaved participants did not report higher rates of doctors appointments or hospitalizations, they did report significantly poorer health ratings, with more recently developed or worsened illnesses and greater use of medications. These findings were independent of sex and socio-economic status.

On the basis of their review of the literature pertaining to sex

differences in health risks to the widowed, Stroebe and Stroebe (1983) concluded:

> if there is any sex difference at all, bereavement affects the physical health of men more than that of women. The failure to find a deterioration in the physical health of a sample of elderly bereaved persons (Heyman & Gianturco, 1973) is in line with one trend found in bereaved mortality studies - the loss effect is strongest in the younger widowed and weakens with increasing age. (p.290)

In summary, it appears, then, reasonable to expect increased frequencies and types of physical health problems in bereaved individuals, especially males. The particular variables associated with the degree of increased risk for any one individual, and how such variables interact, are not yet clear.

The following section will discuss social networks as they relate to bereavement outcome.

Social Network

The first attempts to systematically characterize social networks was done by British social anthropologists in the 1950's, while studying life in a Norwegian fishing village. J.A. Barnes (Mitchell & Trickett, 1980) began to plot the interactions that an individual had with others in an attempt to graph that person's social field, or "personal network". Since that time, the importance of social support for individual well-being has been suggested by theorists from a variety of fields including psychology, social work, family therapy and community mental health (Mitchell& Trickett, 1980).

Social network refers to the configuration of significant

relationships which make up an individual's social support system. Support systems have been defined as "an enduring pattern of social ties that play a major role in maintaining the psychological and physical integrity of the individual" (Greenblatt, Becerra, & Serafetinides, 1982, p.977). Social networks serve to mobilize the resources of the individual and assist him or her in bearing emotional burdens. Network members share labor and skills, give guidance, and provide tangible assistance such as money and materials. Through participation in social networks, people experience a feeeling of belonging, and satisfy their most basic emotional needs through the exchange of love, affection, dependence and control (Greenblatt, et al., 1982).

Social support systems can be thought of as formally recognized entities such as family, church or social organizations, or self-help groups, but it is usually some cross-section of these that makes up the particular set of individuals that serve as a reference group for a given person. The concept of social network presents one way of examining the total social field in which a person functions (Mitchell & Trickett, 1980).

The structure of a network can be described in terms of size (number of people within the network) and density (the extent to which the members of an individual's network know and contact each other independently of him or her), The relationships that make up the links in the network can be examined for the characteristics of intensity of feeling, durability, and multidimensionality (whether a given

relationship is used as a source of one or more types of exchange - information, support, etc.). Directedness and reciprocity (how much does the focal person give affective and instrumental aid in comparison to how much she or he receives), how many functions each relationship serves, dispersion (the ease with which the focal person can contact network members; usually geographic), frequency of contact, and homogeniety are also part of the network. Common normative designations of relationships are primary kin, secondary or extended kin, friend, neighbor, and work acquaintance (Mitchell & Trickett, 1980).

In efforts to operationally define social network, researchers have selected criteria varying in terms of (a) how many members of a network are included; (b) whether frequency of contact or the focal person's view of an individual's significance determine if the individual is listed; (c) what frequency of contact is sufficient to warrant an individual's being considered an"active" member of the focal person's network. Mitchell and Trickett (1980) draw ten different operational definitions for social network membership from the literature. These criteria range in inclusiveness from requiring the focal person and the network member to know each other by name and have an ongoing personal relationship with contact every six months, to simply asking the focal person to name the people outside the immediate household he or she feels closest to, or the number of friends who live within a ten minute walk of his or her home.

In their overview of social networks as related to mental health,

Greenblatt et al. (1982) note that the significant others who make up an individual's social network may fulfill different functions in response to different types of need. For example, relatives may provide most of the long-term support, neighbors provide more emergency services, and friends contribute to the solving of personal or social problems. Most evidence, however, points to the nuclear family as being the most influential in providing emotional support. Researching the relationship between social networks, stress and physical symptoms, Cohen, Teresi and Holmes (1985) administered structured interviews one year apart to 133 elderly residents of single room occupancy hotels in Manhatten. The mean age of the subjects was 72.3; there 58 men and 75 women. Taking into account such features of the social network as material and emotional exchange, quantitative and morphological features of the overall network, and environmental features which have been found to influence network formation and composition, they concluded that "social networks exert a direct effect on reducing subsequent physical symptoms," (p. 478), particularly in persons experiencing high amounts of stress.

A number of investigators have suggested the importance of interpersonal support when adjusting to conjugal bereavement. Lowenthal and Haven (1968) described the importance of having a confidant in helping elderly persons adapt to traumatic social losses, including death of a spouse and retirement. In their study of several hundred widowed elderly community residents, those who described themselves as having confidants had better adaptation to bereavement than those who lacked

such intimates. (Adaptation was measured by a satisfaction/depression -"morale"- scoreboard on a cluster analysis of responses to interview questions.) Legget (1979), using questionnaires and informal interviews, found that a sense of belongingness rather than mere involvement (activity level) was the factor most highly correlated with coping ability. Heyman and Gianturco(1973) found that when stability was present in the social network, the elderly were capable of positive adaptation to the death of a spouse, and tended to maintain prior activity levels, showing little decrement in physical and psychological health following bereavement. Using data drawn from structured interviews of 597 men and 952 women, (65 years and over, all Caucasion) in a 1974 national survey, Arens (1982) found that men and women who were widowed were older than those who were married, and spent less time participating in recreational activities. Widowers spent less time socializing with friends than did married men, while the correlation for women was negligble and not significant. Arens (1982) attributed the lower rate of participation and fewer contacts with friends in widowers to greater age, poorer health, and lower level of education. She also found that women, but not men, reported more serious financial problems which appeared to be a direct result of widowhood status, and that women who were employed reported more positive affect than those who were not. She concluded: "A sense of well being in later life generally is improved when persons are closely connected to social life through marriage, friendship, participation in social activities and employment roles" (p. 38).

Vachon et al. (1982) in a two year study of conjugal bereavement, used the 16PF and the General Health Questionairre along with structured interviews at one month, six months, and two years after bereavement to discriminate subjects in "high distress" from those in "low distress". Their sample consisted of 99 urban middle class women aged 27-69 (mean age=54). They found that 26 of the 99 women reported high distress at one month, and that this endured two years later. Of the women enduring high distress, 69% had a deficit in social support (as measured by answers to seven questions such as "Has the nature of your ties with your own relatives changed in the last year?", "How many people do you have that you can really count on?") In comparison only 34% of the 73 women without enduring distress reported a deficiency in social support. In a comment on the apparent complexity of the relationship between social support and other aspects of a person's mental health, they state: "...it seems unlikely that perceived deficit in social support and psychological distress could ever be clearly divided into cause and effect, since not only would one intensify the other, but also the causal sequence could differ from individual to individual" (Vachon, et al., 1982). In a further evaluation of this data, Vachon, Rogers, Lyall, Lancee, Sheldon and Freeman (1982) examined the General Health Questionairre responses of 162 widows aged 22-69 (mean age=52) at one month post bereavement. They found the variable most closely associated with high distress early in widowhood was the woman's perception that she was seeing less of old friends than before her husband died.

Clayton, et al. (1971) noted that interaction with other family members (notably children) was helpful in preventing depression in elderly bereaved men and women. Subjects who were depressed at one month after the death of their spouse had significantly fewer children in the same geographical area from whom they could receive emotional support. Both Smith (1978) and Beckman and Houser (1982) found higher incidences of depression in widows who were childless. However work by other researchers in this area suggests that whether the bereaved elder's relationship with a child is helpful and supportive or a source of stress and discouragement is determined not by their blood tie, but by the dynamics of their interaction. Of critical importance is whether the elder feels dependent or beholden to the child. In a study of 409 elderly widows, Arling (1976) found that contact with their children did little to elevate the widows' morale. However the number of neighbors and friends a widow has was significantly related to less loneliness and worry, and higher morale. Since frequency of contacts with neighbors and friends was not significantly related, Arling speculated that perception of oneself as an integral part of a supportive neighborhood system was the influential factor behind his results. He used these data to support his contention that friendship and neighboring relationships usually develop voluntarily, and are based on common interests, lifestyles and a more equal ability to exchange assistence. In contrast to this, in old age the widow may see her remaining family as bonded to her by obligation, and experience a role-reversal with her adult children as they begin to take care of more and more of her

needs, which may leave her feeling despondent over her new dependent role (Arling, 1976).

In summary, a social network is the configuration of significant relationships that provides an individual with social contact, emotional and physical assistance, and a sense of belonging. Certain characteristics of social networks have been found to be associated with fewer physical health problems and less psychological distress in the elderly, both bereaved and non-bereaved. These include stability, the presence of a confidant, and the perception of self as part of continuing supportive network. Close contact with one's children has been found to be correlated with less depression in some older widowed persons but not others. This inconsistency may be related to how independent the older person feels in relationship to his or her children. Present literature supports the relevance of further examination of the relationship of social network to bereavement outcome in the elderly. The following sections will discuss current theories regarding the process of grieving (the emotional and behavioral stages that follow bereavement), and the relevance of anticipatory grief to widowhood adjustment.

Grieving

Process

Lindemann (1944) described the process of grieving as having both affective and behavioral components.He defined the affective component as the individual's need to accept the discomfort of

bereavement, deal with the memories of the deceased, and express emotions. The behavioral he defined as the need to adjust to an environment in which a significant other is missing, to form new relationships, and to do whatever is needed to achieve "emancipation from bondage" to the deceased. From a more sociological perspective, both Lopata (1973) and Peterson and Briley (1977) described the need for individuals to experience a process of grieving in order to eventually recover and continue independent lives.

Fell (1977) defined normal grief reactions as "those that are successfully resolved by the individual himself without lasting impairment" (p.17). Gelcer (1983) gave a more pointed view on the value and necessity for grieving: "The reciprocal interplay between mourners and their social support systems ideally leads to maturation and to learning to give up what is obsolete, to assume new roles, and to take on new life tasks. The ill effects of bypassing mourning, however, evolve into family and social pathology" (p.504). When the process of grieving is thwarted in some way, an abnormal pattern of grieving may occur. Several types of abnormal grieving have been described in the literature. Lindemann (1944) reported that a delayed grief reaction may occur if the survivor initially denies the reality of a loved one's death. Some reminder of this loss, such as an anniversary that occurs a year or more later, may suddenly bring the unresolved grief to the surface with great force (Fell, 1977). Zisook and DeVaul (1976) described what they called "grief-related facsimile illness", in which the survivor pathologically overidentifies with the deceased to the

point of developing the physical symptoms present in his or her last illness. Inhibited grief results when the survivor grieves in a passive, unexpressive manner for a long time. Chronic grief occurs when the normal, evolutionary process is halted, and the survivor seems to be "stuck" maintaining the same intensity or type of feelings or cognitions too long, so that the grief never seems to be resolved. Such an individual never achieves closure regarding his or her loss, and never seems quite able to get on with the process of living (Fell,1977).

Much of the literature on bereavement has been devoted to the issue of whether grieving, which so clearly seems to occur as a process rather than as a static achievement, progresses through a series of separate, recognizable stages which are basically the same for all people. Based on his observations of the survivors of victims of a nightclub fire, Lindemann (1944) originally espoused the concept of stages or phases in the process of normal bereavement. He described the first stage as initial shock, numbness, and denial. The second stage he described as pining for the lost loved one, and depression, which initially peak one to two weeks after the death but may continue for months. It is during this time, Lindemann claimed, that the process of grieving or "grief work" takes place. In the third stage, the bereaved person achieves a sense of emancipation from the deceased and adjusts to the new environment. Finally, in the fourth stage, identity reconstruction occurs as new relationships and new roles are formed (Greenblatt, 1978). Engel (in Fell, 1977) described

three stages of successful grieving. In the initial stage which may last minutes to days, the bereaved individual feels stunned, shocked and disbelieving. Engel interpreted this as the result of some psychological mechanism designed to mitigate what might otherwise be overwhelming stress. The second stage he described as a return to emotional awareness. Feelings to be expected at this point include anger, emptiness, guilt and self-condemnation, of which the latter two are likely to be projected onto others, especially relatives and medical personnel. Engel believed the third stage to be the period of actual grief work, in which the mourner deals with the painful void created by the lost love object. He suggested that after a process of reminiscence and idealization of the deceased, the survivor is strengthened and left free to face reality again. He estimated the average normal grief work period to be one year, after which, if the work has been successful, the survivor will be able to comfortably and realistically remember the good and bad qualities of the deceased (Fell, 1977).

Bowlby (in Hardt, 1978) also described three stages of mourning, but applies different constructs to them: first, the mourner craves angrily to recover the lost person, and in doing so often reaches out to others for support; second, the mourner's behavior patterns become disorganized as he or she disengages from old ways and in so doing becomes open to relating to new objects or people; and third, the person is once again able to find satisfaction in living. Hardt (1978) administered a Death Attitude Scale to 692 thirteen to twenty-six year

olds of both sexes. Based on the results of this data he suggested that mourners pass through five stages over a period of about eight months, before reorganizing or accepting the death of the loved one. These are denial, false acceptance, pseudoorganization, depression, and reorganization/acceptance. In her 1980 review, Balkwell described a four stage process of grieving among widowed persons that begins with a one day to two month period of shock, bewilderment, possible denial of the death, and restless, aimless activity alternating with numbed stupor. Approximately the first month to first year of widowhood constitutes the second stage, marked by a sharp rise in affect similar to that described by Engel and Lindemann (see above). During this period, the mourner may disengage from social relationships as loneliness for the deceased spouse is acutely felt. The third stage Balkwell describes is a "limbo-like exploratory phase" (p.120) marked by difficulty making decisions and attempts to try on new roles, along with depression and dependency on others. Finally, when grief work is completed, the individual feels an easing of pain, a sense of being less at a loss and more settled, and may accept his or her widowed status or be engaged in new roles and relationships. (Balkwell, 1981).

In discussing grief adjustment as it pertains particularly to widows, Barrett and Schneweis (1980) went one step beyond discussing just the process of initial stages of grieving to hypothesizing that stages might be found to describe the developmental life of widows over years of post-bereavement survival. C.J. Barrett (Barrett & Schneweis, 1980) observed in work with groups that women who had been

widowed for varying lengths of time frequently made comments which seem to reflect a perception of distinct periods of adjustment beyond the resolution of grief (or beyond the first year or so of bereavement). "Widows in groups consistently inquire about the duration of other's widowhood, as if this is necessary information for comprehending their situation. This knowledge also appears to affect the particular advice one widow has for another" (Barrett & Schneweis, 1980, p.98). When meeting in discussion groups, women reported common experiences that seemed to relate to the extent of time which had passed since the husbands's death. For example, several long-term widows reported severe second depressive reactions that had onset when they realized they probably would never marry again. Several middle-aged widows described a pattern of initially feeling disgust towards men and rejecting all physical contact with them, followed by a period of an almost fierce resurfacing of sexual desire. Some widows further reported an eventual reorienting of their sexual selves, when they were finally no longer completely rejecting of sexual intimacy nor indiscriminately seeking it.

Prompted by these observations and supported by life-span developmental theory, Barrett and Schneweis (1980) analyzed data drawn from an extensive needs assessment survey of the elderly in Wichita to determine if needs and existing resources experienced by widowed persons varied in accordance with the number of years they had been widowed. Using a representative sample of 147 widows and 42 widowers aged 62 and over (mean age was 74.4 years; median time widowed was 8.4

years), they tested 151 dependent variables in the areas of psychosocial needs, nutrition, health care, household help, transportation and educational needs. When they divided the subjects into six categories of widowhood duration from less than 3 years to over 20 years, only 6% of the variables were found to differ significantly by duration of widowhood, less than would have been expected by chance. Based on these results, Barrett and Schneweis concluded they could not confirm the existence of separate stages of adaptation to widowhood, but that it was clear that the nature and degree of stresses resulting from widowhood persist for years after the spouse's death.

The similarities between many of the stages of grieving outlined by the above authors suggests that some commonality of experience does occur among bereaved individuals. Initial emotional numbing, followed by acute grief seems fairly universal. How long such early stages last, and how long full recovery or resolution of the loss takes seems to vary greatly among individuals. The relationship of the survivor to the deceased, and the age at which the deceased passed away (the latter indicating how much the deceased might have reasonably been expected to be likely to die) are certainly important factors in determining the impact a specific death will have on a specific survivor. The different conclusions reached by the above authors reflect not only their own interpretative constructs, but the characteristics of their differing subject pools (particularly age and relationship to the deceased) and their differing choices of dependent variables by which to assess their subjects' state of grief.

Anticipatory Grief

Gerber et al. (1975) defined anticipatory grief as the opportunity for emotional preparation that comes when persons have advance warning of their loved one's impending death. Anticipatory grieving has been hypothesized to increase the widowed person's ability to cope with the loss, and decrease vulnerability to adverse physical, psychological and social reactions to the death. As Weisman noted (in Welch, 1982) "Anticipatory grief...provide(s) a means of setting in motion a unique process of relinquishing a key person and then filling a void"(p.156). Glick, et al. (1974) suggested that anticipatory grieving provides a chance to understand the cause of death and to give up false hopes. Research in this area, however, has frequently yielded data which has not supported these expectations. Some links between anticipatory grief and mourning have been established, but results have been inconclusive and operational definitions often muddled (Gelcer,1983). Examination of these apparently conflicting results reveals that the impact of forewarning of a loved one's death is mediated by factors which include previous experience with surviving a similar loss, how much forewarning the survivor had, and the age of the survivor at bereavement. As Gelcer (1983) stated:

> Adjustment through anticipatory grief would normally be expected to result in gradual emotional disengagement by the various members of the family commensurate to the dying member's capacity for involvement with others. More often for those inexperienced with death, there seems to be rather an increased emotional involvement with the dying member (p. 501).

Welch (1982) administered a twelve-item questionnaire compiled

from Faschingbauer's Texas Inventory of Grief to 41 family members of adult cancer patients in an acute care setting, to assess their current level of grieving. She found that of all the subgroups she evaluated, elderly (age 60 and over) relatives had the lowest total scores, suggesting they were experiencing the least amount of unresolved grief. She also found that relatives who had previously lost a loved one to cancer had, as a group, a lower average score. (Although Welch did not suggest it, it seems likely that many elderly subjects would also have been in this latter group simply by virtue of having lived long enough to have more chances to outlive loved ones and by so doing to obtain experience in dealing with grief.)

In her investigation of the impact of survivor age and forewarning of spouse's death on the grief process in widows, Ball (1977) administered questionnaires to 81 widows, interviewing nineteen of them. Subjects were grouped by age (18-46, 47-59, 60-75), and by mode of spouse's death (five days or less after onset of illness/ no opportunity for anticipatory grief, versus six days or more after onset of illness/opportunity for anticipatory grief). Ball found that among the youngest group of widows, those who had opportunity for anticipatory grieving showed markedly fewer symptoms of acute grieving. This relationship was less marked among middle-aged and older widows. Young widows generally showed higher levels of distress, particularly when the spouse had died suddenly. She concluded that after a certain age (about 45 years) anticipatory grief does not impact bereavement adjustment in women, and that sudden death of a spouse is more

traumatic generally for younger women than older ones. Clayton, Halikas, Maurice, and Robins (1973) reported that survivors with a mean age of 61 who had opportunity for anticipatory grief did not differ significantly in depression one year after the death from those who had no such opportunity.

When the length of time the deceased was ill prior to death is taken into account, a more complete picture of the effects of anticipatory grief on the elderly can be obtained. Fell (1977) noted that when a chronically ill spouse had been nursed by the bereaved, a situation common among the aged, the caregiver may have been under extreme stress for an extended period of time. When the spouse finally dies, the survivor may respond with relief as well as sadness.

Sanders (1982) interviewed 86 people (mean age was 52) who had lost a family member an average 2.2 months after the death, then 18-24 months later. Approximately half the subjects had lost a spouse, the remaining had lost a parent or a child. At the 18-month follow-up, she found that survivors of a sudden death situation had suffered significantly more hospitalizations than those who'd had some warning of impending loss. Using the Grief Experience Inventory, the MMPI, and recent physical health data she found that, over-all, individuals who lost a loved one after a short term chronic illness (with less than six months warning) were better adjusted than those who had experienced the sudden death of a relative, or those whose deceased loved ones had been chronically ill for six months or more. The sudden death survivors showed more anger and guilt along with their higher

rates of medical problems, while the survivors of a long-term chronic illness death reported greater social isolation, loneliness, and loss of vigor which seemed to be prolonging their grief. They were also more likely to deny their own emotional needs as part of their method for surviving bereavement. Sanders attributed the better adjustment of the short-term chronic illness death survivors to the opportunity they had to "complete old business" with the deceased and to make restitution. She speculated that individuals in this group also were spared the physical and emotional drain of having to cope with a relative's prolonged illness (during which time social contacts and supports could easily be lost track of, as the survivor's attention was continuously focused on the ill family member.)

Schwab, Chalmers, Conroy, Farris and Markush (1975) and Gerber, et al. (1975) both found that elderly men and women whose spouses died after long illnesses (six months or more in duration) showed poorer medical adjustment than those who's spouse's deaths followed illnesses of less than six months. Gerber and associates also found poorer physical health among widowers than widows after prolonged last illness of a spouse.

In summary, it appears that "forewarning is important when the likelihood of being widowed is very small (i.e. among the young) and when the bereaved individual may have had some reason to wish to 'make peace' with the spouse before his death" (Balkwell, 1981, p.122). Among the elderly, prolonged illness of a spouse may disrupt the pattern of social interaction, lead to an overinvestment of energy into

the role of caregiver, and leave the individual physically exhausted. All of these may combine to make adjustment to widowhood, with its accompanying new roles, more difficult at a time in life "when the number of available new roles may be limited by societal and/or physical constraints" (Balkwell, 1981, p.122).

Summary

The review of the literature on grief adjustment among the elderly indicates that widowed persons experience multiple problems and that a number of complex social-psychological variables interact to modify the impact experience. Characteristics of the bereaved individual's social network, and his or her opportunity for anticipatory grieving have been shown to be related in many cases to bereavement adjustment. The degree to which these variables have impact is usually measured in terms of how related they are to measures of mental health (frequently focusing on depression) and physical health (as assessed by such things as the number of illnesses, hospitalizations, medications, and subjects' perceptions of their own health).

While the factors listed above have been shown to be related to bereavement outcome, it is not clear which subgroups among the bereaved they affect most. Nor has it been determined to what degree they relate with each other in affecting grief adjustment. Although much research has been done on the bereavement process, many studies have had methodological problems including an absence of control

conditions and lack of longitudinal design strategy, making it difficult to assess changes over time. Some of the self-report instruments used in assessment have not been evaluated for appropriateness with a geriatric population, necessitating cautiousness in evaluating results derived from them.

A major threat to external validity in most of the research in this area is biased sample selection from two sources. First, certain subgroups of widowed persons are underrepresented in the research, including men, the elderly (though this obvious oversight has been greatly remediated over the last ten years), and residents of non-urban areas. The latter have been almost completely excluded from sample selection, probably because sufficient numbers of subjects can be gathered more conveniently and quickly in more densely populated urban areas. Enough differences have already been discovered in the bereavement experiences of different types of widowed persons that generalizations about how different variables interact to produce adjustment cannot be confidently made until the population of widowed persons has been more representatively sampled. Second, random samples of subjects are not usually available. Studies generally depend on volunteers. Also, while volunteers are usually described to some extent, almost never is any description given of the characteristics of those who decline to participate. (Such descriptions serve to illuminate bias in the sampling procedure.) Since most research has focused on uncovering what the variables are that impact grief adjustment, there still exists a need to examine how these variables

interact. This study will contribute to meeting this need by exploring how social network and anticipatory grieving impact depression and perceptions of physical health in rural, elderly, recently widowed men and women.

CHAPTER III

METHODOLOGY

In this chapter the research methodology will be presented. Included will be the purpose and hypotheses of the research, a description of the sample, procedures followed, a description of the measures used, and the methods used in testing the hypotheses.

Purpose of the Study

There is a deficit in the literature pertaining to factors which influence adjustment to the bereavement experience. The purpose of this study was to attempt identification of variables which may enhance the ability of bereaved individuals to cope with the process of widowhood.

Objectives

1. The first objective of this study was to determine the relationship between depression and certain variables which the present literature suggests most influence the dysfunctional effects of depression (gender, social network, level of grief and opportunity for anticpatory grieving).

2. The second objective was to determine the relationship between these same variables and elderly persons' perceptions of their own physical health.

Hypotheses

To accomplish the study's described objectives, two hypotheses were examined:

1. There is no relationship between depression (as measured by the Beck Depression Inventory) and the following variables: gender, bereavement status (widowed or control), social network, and current level of grieving (as measured by the Texas Inventory of Grief), and the opportunity for anticipatory grieving. (This last variable was assessed for the widowed subjects only.)

2. There is no relationship between subjects' perceptions of their own physical health and the variables listed in the first hypothesis.

Sample

In order to obtain participants for the bereavement sample, local newspaper obituaries in the northern Utah, southern Idaho area and death certificates at the Bear River Health Department were searched periodically. Spouses of persons over 55 who had died within the preceeding 3 to 6 weeks were mailed a description of the project, along with a card on which willingness to be interviewed could be indicated, and a stamped self-addressed envelope. (See Appendix A for a sample of the introductory letter to the bereaved.) Mailings were sent to 406 persons. Of these, 130 originally expressed a willingness to participate by indicating this on their reply cards or in followup

phone calls. Those to whom a phone call was made had not returned their reply cards within three weeks after they were presumed to have received them. Seventy-five, or 58% of the 130, were found to fit the guidelines for inclusion in the bereaved subject group, i.e. over 55 years of age, recently widowed, and Mormon, yielding a sample of 24 men (mean age=72.5) and 51 women (mean age=67.7). The remaining were not interviewed because first interviews were not able to be arranged within the 10 week time limit after the spouse's death, because individuals lived too far away to make interviews practical, because persons who originally agreed to be interviewed withdrew their permission when asked to actually set an appointment time, or because of non-Mormon status.

Participants for the control sample were recruited through the same mailing procedure from among attendees at a workshop related to elderly issues, and from names suggested by the bereaved subjects, who were asked to suggest acquaintances of theirs who fit the guidelines for inclusion in the control group. These guidelines included persons age 55 and over, Mormon, who had not lost a spouse through death or divorce within the past five years. Introductory letters were mailed to 127 persons, of which 23% were eventually interviewed, resulting in a control sample of 16 women (mean age=63.7) and 13 men (mean age=66).

Where reasons for refusal to participate could be obtained, either on reply cards or in follow-up phone calls, these reasons were recorded. See Appendix B for a list of the types of reasons given, and the percentages of each given by bereaved and control non-participants.

See Table 1 and Table 2 for a summary of demographic information on the bereaved and control participants.

Table 1

Demographic Variables (Means and Standard Deviations) by Group and Gender

	Bereaved		Control	
Variable	Men (n=24)	Women (n=51)	Men (n=13)	Women (n=16)
Age	72.5 (8.77)	67.7 (9.45)	66.1 (8.53)	63.8 (8.16)
Education	4.3 (2.35)	3.3 (1.55)	5.0 (2.1)	4.9 (1.67)
Income	3.7 (1.45)	3.3 (1.19)	4.5 (0.80)	4.5 (0.73)
Perception of income	4.0 (1.08)	3.5 (0.84)	3.8 (0.62)	3.8 (0.70)
No. of children living	3.2 (1.98)	4.3 (1.86)	4.0 (2.06)	4.5 (2.03)

Note: Standard deviations are in parentheses.
Education was coded (1=elementary school; 2=some high school; 3=high school graduate; 4=vocational school graduate; 5=some college; 6=BS, BA, RN; 7=some graduate school; 8=completed graduate degree)
Income was coded (6=30,000.+ ; 5=20,000.+ ; 4=10,000.+ ; 3=5,000.= ; 2=3,000.+ ; 1=less than 3,000.)
Perception of income was coded (7=wealthy; 6=well-to-do; 5= more than enough to get by; 4=comfortable; 3=have just enough to get by; 2=can get by with some help; 1=cannot make ends meet)

Table 2

Demographic Variables

by Group and Gender, cont'd.

	Bereaved		Control	
Variable	Men	Women	Men	Women
Living arrangements				
Living alone	91.7%	76%	.00%	.00%
w/ one other	.00%	14%	58.3%	68.8%
w/ two others	8.3%	10%	41.7%	31.3%
Residence				
Owned own home	95.8%	93.9%	100%	100%
Rent single dwelling	4.2%	2.0%	0.0%	0.0%
Rent apartment	0.0%	2.0%	0.0%	0.0%
Other	0.0%	2.0%	0.0%	0.0%

Procedures

Data was gathered at two intervals. For the bereaved participants, the first interview was conducted within 10 weeks of the spouse's death; the second was conducted six to eight months after the spouse's death. The control participants were administered the two interviews six to eight months apart. Data was gathered by means of structured interviews administered in participants' homes, and two self-report instruments: the Beck Depression Inventory, and the Texas Inventory of Grief. Interviews were conducted by volunteer adults who underwent approximately eight hours of intensive training by members of the Utah State University Psychology Department faculty. Self-report instruments were left with the participants after each interview, along with a stamped, self-addressed envelope for ease in returning them to the university.

Data and Instrumentation

A total of 13 variables were used in this study. Independent variables examined for both bereaved and control subjects at both sampling times included:

(a) bereavement status (bereaved or control);

(b) gender;

(c) current level of grief, as measured by the present grieving score obtained on the Texas Inventory of Grief;

(d) social network (each of the following variables was considered independently)

(1) the number of family members each subject reported as being important in his or her life now, up to a maximum of 10;

(2) the average frequency of contact with each important family member (using the following rating scale: 7=every day, 6=several times a week, 5=once a week, 4=several times a month, 3=once a month, 2=once every two or three months, 1=less than every two or three months);

(3) the average degree of feelings for each listed important family member (using a 1 to 7 rating scale with the following following values: 7=very positive, 4=mainly neutral, 1=very negative);

(4) the number of non-family persons each participant listed as important in his or her life now, up to a maximum of 10;

(5) the average frequency of contacts with important non-family persons, using the rating scale listed under variable (2);

(6) the average degree of feelings for important non-family persons, using the rating scale described under variable (3).

The following two variables were examined for bereaved subjects only:

(a) whether the death of the spouse expected, yes or no;

(b) the length of the deceased spouse's last illness, from 00 to 98 months.

The variables above were tested for their relationship to the following dependent variables:

(a) depression, as measured by the Beck Depression Inventory; and

(b) a total score for self-ratings of physical health, obtained by adding together each individual's scores on two questions. These were: "Overall, how would you rate your health at this time?" (coded on a scale from 1 to 7, with 7="very good", 4="average", 1="very poor"); and "How does your health now compare to others your age?" (coded on a scale from 1 to 7, with 7="much better", 4="about the same", 1="much worse").

Instrumentation

The following self-report instruments were administered to all subjects, at both interview times.

Texas Inventory of Grief (TIG). This 26-item scale was developed to measure the intensity of grief reactions, and to assist in diagnosing unresolved grief. It provides separate scores for Past Behavior (8 items) and Present Feelings (13 items). Respondants are asked to indicate to what degree items such as "I still cry when I think of the person who died" are true for them, from completely true to completely false, using a scale from 1 to 5. It was developed on several small samples of patients in an outpatient unit of a psychiatric clinic, including widowed persons, who had lost one or more close relatives. Persons who had experienced the recent death of a loved one had a significantly higher mean score than those for whom the death occured more than two years earlier. Reliability of the inventory has been determined to be .81 (split-half) (Faschingbauer,

et al., 1977).

Beck Depression Inventory (BDI). This scale provides a quantitative index of the intensity of depression. Its 21 items tap into cognitive, affective and somatic elements of depression. The items are graded in severity along a four-point continuum ranging from absence of the symptoms under question to crippling severity. Reliability of the BDI has been determined to be .86 (Pearson 'r'). Concurrent validity has been reported to be from .58 to .73, in comparison with other standardized measures of depression (Beck & Beamsderfer, 1974; Gallagher, et al. 1983). (See Appendix C for copies of the TIG, the BDI, and the structured interview.)

Interview Instrument. The structured interview from which data on self-ratings of physical health, social network, and descriptive data were obtained was developed at the Andrus Gerontology Center at the University of Southern California. It had undergone five pilot studies and subsequent revisions prior to its use in the present research.

Analysis

To test the hypotheses described above, a series of eight stepwise multiple regressions were done, all using foreward inclusion.

Time 1

Four of the regression equations used data drawn from the first interview and self-report data. In the first regression equation, the independent variables of bereavement status (bereaved or control),

gender, social network, and current level of grief were entered into the regression to determine their relationship to the dependent variable, Beck Depression Inventory scores. To test for a possible relationship between the two dependent variables, self-ratings of physical health were also were also entered into the regression equation.

In the second regression equation, the same independent variables were entered to determine their contribution to the variance of the independent variable of self-ratings of physical health. To test for a possible relationship between the dependent variables, depression was also entered into the regression equation.

In the third regression equation, only data drawn from the bereaved subjects was included. In this regression equation, the variables related to anticipatory grieving were added in with the other independent variables, to determine the relationship of anticipatory grieving to depression scores. The fourth regression equation followed this same procedure, but with self-ratings of physical health as the independent variable.

Time 2

The final four regressions were performed using data from Time 2. They were carried out according to the manner described above.

The following chapter presents the results of these analyses.

CHAPTER IV

RESULTS

This study focused on two factors which the literature suggests are related to how the elderly adjust to the loss of a spouse, namely depression and self-ratings of physical health. The objectives of this study were to determine to what degree the variance in these factors can be explained by the following mediating variables: gender, bereavement status, present level of grieving, opportunity for anticipatory grieving, and social network. The relationship between the two dependent variables, depression and self-ratings of physical health, was also considered. Hypotheses were then presented to forward the study's stated objectives. The results of the analyses which tested these hypotheses are presented in this chapter.

For organizational purposes, the analyses pertaining to depression, using data gathered from Time 1 and Time 2 will be presented first. Following this, the analyses pertaining to self-ratings of physical health at Time 1 and 2 will be reported. Analysis of the impact of opportunity for anticipatory grieving and its effect on depression and self-ratings of physical health will then be reported separately, since these data pertain only to the bereaved subjects and therefore had to be analyzed separately.

Depression

Hypothesis 1. There is no relationship between depression (as measured by the Beck Depression Inventory) and the following variables:

gender, bereavement status, social network, current level of grief, and opportunity for anticipatory grieving.

Two multiple regression equations were performed to assess which combination of variables would best predict depression in the present sample at the time of an initial interview (performed within two months after bereaved subjects suffered the loss of their spouses), then again six to eight months later. At Time 1, the following independent variables combined to account for 35% of the variance in depression scores: self-ratings of physical health, (the lower the rating, the higher the depression was likely to be); present level of grief (higher grief scores were related to higher depression scores); and the number of family members a subject listed as important in his or her life now (lower numbers here were associated with higher rates of depression). Self-ratings of physical health alone accounted for 18% of the variance, level of grief for an additional 11%, and number of important family members for the final 7%. The remaining variables did not contribute significantly to explaining the variance. These included sex, bereavement status, the number of non-family important people in the subject's life, frequency of contact with family or non-family important people, or average feelings toward important family or non-family people. See Table 3 for further information on the results.

At Time 2, participants' present level of grieving (as measured by scores on the Texas Inventory of Grief) and frequency of contact with important non-family persons (such as friends, neighbors and clergy) combined to explain 43% of the variance in depression scores. Grieving

level alone accounted for 35% of the variance. Self-ratings of physical health were no longer related significantly to depression scores as they had been at Time 2. See Table 4 for these results.

Self-ratings of Physical Health

Hypothesis 2. There is no relationship between subjects' perceptions of their own physical health and the following variables: gender, bereavement status, social network, present level of grief, and the opportunity for anticipatory grieving.

A multiple regression analysis performed on data from Time 1 revealed that 27% of the variance in self-ratings of physical health was accounted for by the combination of depression scores and the degree of positive feelings reported for important family members. Depression was negatively correlated, and by itself accounted for 19% of the variance. See Table 5 for results of this analysis.

The regression analysis performed on data from Time 2 revealed that only two of the possible variables combined significantly to explain 18% of the variance in self-ratings of physical health at this point. Both of these were aspects of participants' social networks: average frequency of contact with important non-family persons; and average degree of feelings toward important non-family persons. Each accounted for approximately 9% of the variance. See Table 6 for further details.

TABLE 3

Regression with Depression as the Dependent Variable - Time 1

Analysis of Variance

	DF	Mean Square	Significant F	R Square
Regression	2	128.73558	.0000	.3519
Residual	33	15.84347		

Variables in the Equation

Variable	B	T	p
Self-reports of physical health	-0.604050	-3.220	.0022
Present grieving	.121403	2.439	.0181
# of important family members	-0.942258	-2.354	.0223

TABLE 4

Regression with Depression as the Dependent Variable - Time 2

Analysis of Variance

	DF	Mean Square	Significant F	R Square
Regression	2	910.35890	.0000	.4274
Residual	41	1219.82292		

Variables in the Equation

Variable	B	T	p
Present Grieving	.315946	5.061	.0000
Frequency of Contact /Non-family	-1.531538	-2.406	.0207

TABLE 5

Regression with Self-ratings of Physical Health as the Dependent Variable - Time 1

Analysis of Variance

	DF	Mean Square	Significant F	R Square
Regression	2	66.18056	.0002	.27121
Residual	54	6.58656		

Variables in the Equation

Variable	B	T	p
Depression	-0.271891	-3.870	.0003
Feelings toward Family	1.265632	2.456	.0173

TABLE 6

Regression with Self-ratings of Physical Health as the Dependent Variable - Time 2

Analysis of Variance

	DF	Mean Square	Significant F	R Square
Regression	2	17.22412	.0170	.18021
Residual	41	3.82222		

Variables in the Equation

Variable	B	T	p
Frequency of Contact/ Non-family	.652180	2.697	.0101
Feelings toward Non-family	.944309	2.139	.0385

Anticipatory Grieving

Hypothesis 1. There is no relationship between depression...and the opportunity for anticipatory grieving.

Hypothesis 2. There is no relationship between self-ratings of physical health...and the opportunity for acticipatory grieving.

Four additional regression equations were performed on data drawn just from the bereaved subjects. In these regression equations, two variables specifically related to anticipatory grieving were added to the list of independent variables previously used to explain the

variances in depression and self-ratings of physical health. These were a) whether the spouse's death had been expected, and b) the length of the deceased spouse's last illness, in months. Two regression equations examined the influence of anticipatory grieving on depression and self-reports of physical health, using data from the Time 1 interviews. Two more regressions were used to repeat this same analysis using data from Time 2.

As background information, a descriptive look at the data on these new variables revealed that 50.7 of the bereaved subjects reported that they had expected their spouse's death; the remaining 49.3% indicated the death was unexpected. The length of the deceased spouses' last illness ranged from 0 to 8 years. However, over 50% of those whose spouse had been ill reported an illness length of 5 months or less. See Table 7 for the breakdown of illness length by frequency.

Regarding depression, neither of the variables related to anticipatory grieving contributed significantly to explaining the variance either at Time 1 or at Time 2.

At Time 1, whether the spouse's death was expected accounted for 9% of the variance in self-ratings of physical health. This variable, in combination with depression (19%), and degree of feelings toward important family members (13%), 41% of the variance in self-ratings was explained. (See Table 8.) In the final regression equation, data on the bereaved subjects from Time 2 plus the antipatory grieving variables were tested for their relationship to self-ratings of physical health at 6 to 8 months post-bereavement. At this point

depression (24%), and whether the spouse's death was expected (11%) combined to explain 35% of the variance in self-ratings of physical health. (See Table 9.)

TABLE 7

Anticipatory Grieving: Length of Deceased Spouse's Last Illness

Number of months	Frequency	Percent
0	1	1.7
1	6	10.2
2	12	20.3
3	7	11.9
4	1	1.7
5	7	11.9
6	2	3.4
7	1	1.7
8	1	1.7
10	4	6.8
12	3	5.1
15-22	7	11.9
26-72	5	8.5
98+	2	3.4

Note: Total number of subjects reporting illness length=59.

TABLE 8

Regression with Self-ratings of Physical Health as Dependent Variable, and Anticipatory Grieving as an Independent Variable - Time 1

Analysis of Variance

	DF	Mean Square	Significant F	R Square
Regression	3	42.30146	.0007	.40577
Residual	32	5.80768		

Variables in the Equation

Variable	B	T	p
Depression	-0.281692	-3.258	.0027
Feelings toward Family	1.317581	2.488	.0182
Death of Spouse Expected	1.798922	2.229	.0330

TABLE 9

Regression with Self-ratings of Physical Health as Dependent Variable, and Anticipatory Grieving as an Independent Variable - Time 2

Analysis of Variance

	DF	Mean Square	Significant F	R Square
Regression	2	30.07062	.0016	.34770
Residual	30	3.76095		

Variables in the Equation

Variable	B	T	p
Depression	-0.155143	-3.037	.0049
Death of spouse expected	1.493408	2.193	.0362

Summary of Results

Neither bereavement staus nor gender significantly accounted for the variance in depression scores and in self-ratings of physical health. This was true both early in the bereavement experience (Time 1) and after several months of widowhood (Time 2). The most consistently influential variables examined in this study were the level of grief an individual was experiencing, and characteristics of his or her social network. Depression was initially most explained by self-ratings of physical health, the level of grief (as measured by the

Texas Inventory of Grief "Present Feelings" scale), and the number of family members a participant listed as important. After six to eight months, the grief score was still significant, but number of important family members and self-ratings of physical health were no longer as important. The number of non-family important people (friends, neighbors, and clergy, for example) was significant.

Less of the variance in self-ratings of physical health was explained than in depression, but again social network variables were shown to be significant. At Time 1, depression and feelings toward important family members were significant while, at Time 2, increased frequency of contact with and amount of positive feelings toward non-family important persons accounted for what variance was explained (18%).

Anticipatory grieving was found to be related to self-ratings of physical health. Both early in the widowhood experience and six to eight months later, having expected the spouse's death was associated with lower self-ratings of physical health. Anticipatory grieving did not significantly impact depression levels.

The following chapter will present a discussion of these results.

CHAPTER V

DISCUSSION

The general purpose of this study was to investigate the factors that may impact conjugal bereavement on the elderly. In particular, depression and perceptions of physical health were targeted as the aspects of bereavement adjustment to be examined. Several factors which the current literature suggests may mediate adjustment to widowhood were selected as independent variables. These included: gender, bereavement status, social network, level of grieving and anticipatory grieving. The analyses of the results of this study were reported in Chapter IV. This chapter will present a discussion of the results, relating them to relevant literature. This discussion will be organized according to the order of the hypotheses. First, depression and its relationship to the independent variables listed above will be considered. Next, the findings pertaining to self-ratings of physical health in relationship to the independent variables will be discussed. This will be followed by discussion of the limitations of this study and recommendations for future research.

Depression

Gender, Bereavement Status, and Depression

The hypothesis that depression scores are not related to gender and bereavement status was retained. As presented in Chapter IV, the amount of variance in depression scores which was explained by gender

and bereavement status was not significant at either Time 1 or Time 2. This differs from what might have been expected, considering the current literature regarding differing levels of depression between men and women, and the higher depression levels which have been most commonly found among widowed persons in other samples. As has been previously discussed in this paper, in relationship to sex differences, Berardo (1967, 1970) stated that adjustment to widowhood is generally more difficult for men. It is apparant that within the present sample other variables contribute to depression levels to such a degree that whatever unique effects gender and recent widowhood may contribute are not statistically significant.

A (1978) study by Barrett seems to be related here. In her comparison of urban widowed persons with married controls, she found that sex differences in her sample were most pronounced in the areas of psychosocial functioning and ability to meet nutritional and household needs, with men having more frequent problems. These areas have very seldom been considered in the literature for their possible mediating effects on depression. This study also did not examine nutritional or household needs, but social network variables - as shall be discussed later - were found to be related to depression levels. It may be that as more research focuses on such mediating variables, the unique contribution of gender to depression will be shown to be less important than has been believed.

The present finding that the state of being recently widowed did not contribute significantly to differences in depression stands in

contrast to the majority of previous research related to depression in the bereaved. Depression has been called a "normal reaction to the loss of one's spouse" (Balkwell, 1981, p.119), and a common accompaniment of widowhood (Clayton, 1974). Clayton concluded in her 1979 review that the widowed suffer significant depressive symptoms in the first year of bereavement. Conroy (1977) reported that the widowed are at high risk for mental illness, and attributed this risk to the likelihood of changes in economic status, living conditions, social activities and residence. The subjects in the present study, however, experienced stability of residence, income, and perception of income as adequate. Almost all lived in homes they'd owned prior to the beginning of the study. This stability may have helped sustain the mental health of the bereaved and contributed to their maintaining a depression level that was not significantly different from that of the controls.

Gallagher et al. (1983) found higher rates of depression and grieving among widowed persons than among non-widowed controls. Using the Beck Depression Inventory, the Texas Inventory of Grief, and the Brief Symptom Inventory, the bereaved group showed significantly greater distress on all measures. However, the authors also found that background variables including age, income, life occupation, education, and years of marriage were all significantly associated with mental health and grief scores. It is possible that subjects in the present study differed in depresssion from those of Gallagher et al. because they also differed in these background variables.

One might also speculate regarding the finding that bereavement status did not contribute significantly to explaining the variance in depression scores is idiosyncratic, and related to some characteristic of personality found among this particular sample (older Mormons of rural northern Utah and southern Idaho). For example, one could argue that these persons might be in general more reticent, conservative or non-disclosing than elders in other research samples, and simply didn't admit how depressed they truly felt. One method for evaluating such an argument is to compare mean depression scores obtained from the present sample with the sample used by Gallagher et al. (1983), since both studies used the Beck Depression Inventory as their measure of depression. Examination of the data from the Gallagher subjects (which were drawn within two months of the bereaved subjects' spouses) shows that the mean depression score for bereaved men was 7.73 (SD=6.38), and for bereaved women was 10.57 (SD=8.44). The mean depression score for control men was 4.45 (SD=4.27); for control women it was 7.53 (SD=6.67). In the present study, at Time 1 (also two months after the deaths of the bereaved subjects' spouses) the mean depression score for bereaved men was 9.30 (SD=5.66) and for bereaved women was 9.03 (Sd=6.60). For control men the mean depression score was 4.88 (SD=3.60); for control women it was 7.44 (SD=7.25). Depression scores in the present sample appear to be generally in line with those obtained from the sample studied by Gallagher et al. (1983), and do not seem to indicate that reluctance to disclose feelings of depression was

a particular characteristic of the subjects in this study.

Social Network and Depression

The hypothesis that depression is not related to social network was rejected. At both Time 1 and Time 2, variables related to social network (number of important family members, and frequency of contact with important non-family persons respectively) were found to explain a significant portion of the variance in depression scores. This lends further support to the growing body of literature which suggests that a person's social network can provide support sufficient to help offset depression in bereaved and non-bereaved alike. Previous studies have found that having a confidant helps elderly persons adapt to traumatic social losses such as retirement or widowhood (Lowenthal & Haven, 1968). Studies have also shown when stability is present in the social network, as in the rural sample studied by Heyman and Gianturco (1973), the elderly were more likely to show more positive outcomes after widowhood; i.e., maintaining their prior activity levels, and showing little loss in physical or psychological health.

There is evidence that a sense of belonging, or perceiving oneself to be a part of a well-established circle of family or friends may at times be even more important than actual frequency of contact or activity level for lifting a person's mood and facillitating coping (Arling, 1976; Legget, 1979). In the present study, both of these factors - perceiving oneself as connected to a number of important others, and frequency of contact - were found to be related to depression, at different times. At Time 1, the number of family members

a person considered important in his or her life now was significant: the more such family members a person listed, the lower his or her depression score was likely to be. Six months later frequency of contact with important non-related persons (such as friends and neighbors) became significant: more contact was associated with lower depression scores. It may be speculated that this reflects a change over time in the emotional and social needs of the bereaved. In the initial stage of grief (Time 1) a sense of having a strong family support system to belong to was most important. Several months after the initial loss, at Time 2, bereaved individuals may have been ready for and in need of peers with whom to be more actively socially involved. Thus, contacts with friends and neighbors - persons outside the immediate circle of the family - became more significant.

Level of Grief and Depression

The hypothesis that depression is not related to level of grief was rejected. As described in Chapter IV, at Time 1 the level of grief explained more of the variance in depression than any other variable except self-ratings of physical health. At Time 2, six months later, level of grief was the variable most significantly related to depression scores.

This finding suggest that a strong relationship exists between depression and grief. It is not clear however if this correlation exists because of a causal relationship between grief and depression, or if to some extent the constructs of "depression" and "grief"

actually refer to phenomena that overlap (or are essentially the same). Gallagher et al. (1981) did an item analysis of responses given to the Beck Depression Inventory by elderly persons classified as either suffering from "Major Depression", being recently widowed, or as non-depressed, non-bereaved controls. They found that not only did the depressives score significantly higher on the Beck than did the bereaved or controls, but they endorsed different kinds of items. Both the depressed and bereaved subjects endorsed items denoting affective distress, but only the depressives consistently responded affirmatively to items expressing low self-esteem. It may be that more analyses of this type would help clarify the relationship between grief and depression.

Anticipatory Grieving and Depression

The hypothesis that depression is not related to antipatory grieving was retained. Neither having expected the spouse's death nor the length of the spouse's last illness contributed significantly to the variance in depression scores, at Time 1 or at Time 2. However, by Time 2 the variable of length of the deceased spouse's last illness did approach significance ($p=.13$), in the direction of longer spousal illness being associated with higher depression scores after six months of bereavement. It may be speculated that anticipatory grieving did not approach significance until Time 2 because its effects aren't felt in the initial phase of mourning, but only later when the widowed individual must call on all his or her energies to endure and cope with the adjustments that are a part of

widowhood. It is possible that a later follow-up with the present sample of bereaved persons would reveal that variables related to anticipatory grieving do contribute significantly to depression levels at, for example, one year post-bereavement. Such a finding would suggest a mental health correlate to the relationship reported by Schwab et al. (1975) and Gerber et al. (1975),viz., that prolonged illness of a spouse before death leads to poorer physical health adjustment in the elderly. While some forewarning of a spouse's death seems to facilitate grief adjustment in the young (Ball, 1977), in older persons it may become counterproductive if too protracted. The emotional and physical cost to the surviving caregiver may outweigh in the long run whatever benefit is derived from the opportunity for anticipatory grieving. In cases where the dying spouse's illness is prolonged, the strain of caregiving and the demands of enduring every day may prevent the very things that anticipatory grieving has been found to promote in some persons: emotional separation from the dying spouse, and planning for the future.

Physical Health and Depression

In addition to the variables discussed above, the dependent variable self-ratings of physical health was also made available for entry into the regression equation, to test for its possible contribution to the variance in depression scores. Although this was not part of the original hypothesis, it was decided that since no evidence was uncovered in the review of the literature which indicated

that these two variables are not related, to assume no relationship existed would risk overlooking a possibly significant source of variance. As seen in Chapter IV, analysis revealed that at Time 1 depression and perceptions of physical health were indeed related. At Time 1, self-ratings of physical health explained 18% of the variance in depression, more than any other variable. At first glance this may seem like an unremarkable finding. It seems logical to assume that people who see themselves as sickly are more likely to feel depressed, and vice versa. While this may be the case, the relationship between these two variables is shown to be more complex than this by the finding that at Time 2, perceptions of physical health no longer contributed enough as a unique variable to be included in the regression equations as significantly related to depression. Just how depression and perceptions of one's physical health are related is not clear. For bereaved individuals it may be specualted that early in bereavement widowed persons' attention is focused on the self and their own acute sense of immediate loss. If so, they may be more vulnerable to feeling distressed or overwhelmed by what they see as problems in their own physical well-being. Several months later, as their interest shifts from immediate family to reaching out to friends and neighbors, widowed persons may have less time or need to be quite so concerned over their own health. Hence, at that later time the relationship between perceptions of physical health and depression is less strong.

It may also be useful here to consider some results reported by Parkes (1964). In a review of medical records of 44 London widows

(including some aged 65 and over), Parkes found their consultations with physicians doubled in the first six months of bereavement. Of interest here is his finding that younger widows' increased visits were for psychological complaints, while the older women came in complaining of physical symptoms. One may speculate that members of an older generation, less sophisticated as to the notions of psychology or psychiatry, may be more likely to present with the somatic sypmtoms of depression (lack of energy, disturbed sleep, loss of appetite, for example) than to come to a physician to complain of feeling "down", or depressed in mood. It is possible that with some elders the relationship between perception of one's own physical health and depression is, in part at least, that the former expresses the latter.

The findings related to self-ratings of physical health will now be discussed.

Self-ratings of Physical Health

Gender and Self-ratings of Physical Health

The hypothesis that self-ratings of physical health are not related to gender was retained. As noted in Chapter IV, and gender did not account for a significant amount of the variance in depression at either Time 1 or Time 2. The present finding supports the previous work of Thompson, et al. (1984) who found no sex-related differences in self-ratings of physical health among their sample of 212 recently widowed persons over 55, and 162 non-bereaved comparison controls. Heyman and Gianturco (1973) in their longitudinal study of rural

elderly also found no sex-related differences in physical health among their 41 subjects, aged 65 and above. As discussed earlier in regard to the present findings on depression, the similarity between this study's results and those of Heyman and Gianturco may reflect similarity in subject populations, in terms of rural location and stability of lifestyle including living arrangements and income.

The present results do not rule out the possibility that sex-related differences in perceptions of physical health may exist. Stroebe and Stroebe (1983) concluded that if a sex difference exists, bereavement affects the physical health of men more than women. In addition, despite the work of LaRue et al.(1979) who reported self-ratings to be correlated with physicians' ratings of physical health, and of Mossey and Shapiro (1982), who found that perceived health can be used to significantly predict future mortality, caution must be used in interpreting the present results as evidence that no real sex-related differences exist in the actual physical health outcome of bereaved elderly persons. A large body of research suggests strongly that increased physical health problems are associated with the state of being widowed, and much of this research points to the existence of differential physical health outcomes for men and women (Berardo, 1967; Rees & Lutkins, 1967). It may be that the timing of data collection influences findings in regard to sex differences in self-ratings of physical health. Parkes and Brown (1972) interviewed their bereaved subjects between one and four years post-bereavement, and found a significant increase in physical health symptoms in men but not women.

It may be that the physical side effects of widowhood require a longer period of time than six months before manifesting themselves.

Bereavement Status and
Self-ratings of Physical Health

The hypothesis that self-ratings of physical health are not related to bereavement status was also retained. Bereavement status did not contribute significantly to the self-ratings of physical health. This finding is in contrast to the work of Marris (1951) who found that half of his bereaved subjects rated their health as poorer than pre-bereavement, and that of Thompson et al. (1984) who reported that their widowed subjects described their health as significantly poorer than did subjects in the control group. The current finding does support the work of Heyman and Gianturco (1973), however, who concluded that other variables can override the effects of widowhood so that a bereaved person does not experience a resulting decrease in medical adjustment. As has been previously discussed, Heyman and Gianturco particularly focused on stability of social network as an important factor in this regard. Stroebe & Stroebe (1983) noted that the deterioration effect of widowhood on physical health seems to decrease with age, with the very elderly not displaying the medical adjustment problems related to bereavement that younger elderly frequently do. It seems reasonable to suppose that future research will reveal other such mediating variables. It can be concluded at this point, however, that the death of a spouse, as a unique stressor, is not sufficient to induce perceptions of poorer health in persons for

whom other factors, such as well developed social support systems, are in effect. In addition, as with sex-related differences in self-ratings, the timing of the interviews in this study may have been premature to discern changes in perceptions of physical health.

Social Network and
Self-ratings of Physical Health

The hypothesis that self-ratings of physical health are not related to social network was rejected. At Time 1, subjects' average feelings toward important family members contributed significantly to the variance in self-ratings (as did depression scores). At Time 2, a combination of two social network variables alone contributed significantly to the variance. Both of these were aspects of the social network related to non-family relationships: average frequency of contact with important non-family persons, and average feelings toward important non-family persons. Persons reporting more frequent contact and more positive feelings were likely to perceive themselves as being in better physical health. Based on an examination of which aspects of social network were significant at which times, one could speculate that a transition in social focus is undergone during the early stages of grief adjustment. Two months after the loss of a spouse, relationships with remaining family members may be most important, while six months later the significant focus may be on activity with and feelings for persons outside the family circle. This suggests a shift from a primary need for succorance to a need to resume active social involvement with peers.

These results are in line with the conclusions of Cohen et al. (1985) that for elderly people experiencing high amounts of stress, social networks have a direct effect on reducing the later development of physical symptoms. They also lend support to the findings of Heyman and Gianturco (1973), described earlier, that elderly persons who became widowed consequently showed little decrement in physical health. The authors concluded that the stable quality of the social support systems among their subjects was directly responsible for this maintainance of physical well-being.

Level of Grief and Self-ratings of Physical Health

The hypothesis that self-ratings of physical health are not related to present level of grief (as measured by the Texas Inventory of Grief) was retained. This is in contrast to the demonstrated relationship between depression and present level of grieving. Neither at Time 1 or Time 2 did level of grief contribute significantly to explaining the variance in self-reports of physical health. This suggests that whatever relationship grief has to depression, it is not so related to perceptions of physical health. To the writer's knowledge no other authors have addressed this particular issue.

Anticipatory Grieving and Self-ratings of Physical Health

The hypothesis that anticipatory grieving is not related to self-ratings of physical health was rejected. At both Time 1 and Time 2, whether widowed persons had expected their spouse's death contributed

significantly to the variance in the ratings they gave themselves on physical health: those who had expected the death rated themselves as less physically healthy than those who had not. This finding seems related to those of Gerber et al. (1975), Sanders (1982) and Schwab et al. (1975) that elderly men and women whose spouse's were ill for six months or longer showed poorer medical adjustment (physical health) than those whose spouse's had suffered short term chronic illness (less than six months). In the present study, 59 subjects indicated that their spouses had been ill before dying. Of these, 57.6% reported their spouses were sick from 0 to 5 months before they died; the remaining 42.4% had spouses who were ill from 6 months to over 8 years. It may be that the negative effects of prolonged spousal illness led to such negative self-ratings of physical health by the latter 42.6% that whatever benefit the 57.6% who lost a spouse after short term chronic illness may have gained from this opportunity for comparatively short-term anticipatory grieving washed out statistically in comparison.

Depression and Self-ratings of Physical Health

In addition to the variables dicussed above, the dependent variable depression was also made available for entry into the regression equation, to test for its possible contribution to the variance in self-ratings of physical health. This was done rather than to assume that no relationship exists between these two variables. As was seen in Chapter IV, multiple regression analysis revealed that in the early stage of conjugal bereavement, perceptions of physical health

and depression are significantly related. At Time 1, depression scores accounted for 19% of the variance in self-ratings. At Time 2, however, six months later, depression no longer was significantly related. At that point, social network variables pertaining to relationships with important non-related persons (friends, neighbors, etc.) became significant in determining self-ratings of physical health. How this change over time relates to the control subjects is not clear. In regards to the bereaved subjects, however, one may speculate that the close relationship between depression and self-ratings of physical health early in the mourning process reflects a transient focusing on the self, in response to the acute initial pain of loss. Six months later, when the bereaved one begins to rebuild his or her life as a new, single person, other more outer-directed concerns may take precedence.

Summary

Gender and bereavement status were not found to be significantly related to depression or self-ratings of physical health. It was suggested that other variables such as those related to social network may, as in the case of Heyman and Gianturco (1973) have mediated the impact of widowhood in this sample. Social network variables were found to facilitate lower depression scores and higher ratings of physical health. The class of social network variable that was significant varied from Time 1 to Time 2 however. At Time 1, the number of important family members and how positive subjects felt

toward their families were significant, while at Time 2 characteristics of subjects' relationships with friends and neighbors became important. It was speculated that this pattern reflects a change of social focus related to the individual widowed person's stage of mourning.

High levels of grief were closely related to high depression scores, but not to self-ratings of physical health. The nature of the relationship between grief and depression is not yet clear. Expectation of the spouse's death was associated with lower self-ratings of physical health. This supports previous findings that while anticipatory grieving seems to be of value for younger survivors, it can worsen the longterm adjustment of the elderly.

This chapter will conclude with a discussion of the limitations of this study, and recommendations for future research.

Limitations

The sample of elderly persons used as subjects was not intended to be representative of the elderly in general. The sample represented the Mormon elderly in the small rural communities in northern Utah and southern Idaho. These participants generally owned their own homes, perceived their incomes as adequate, and described themselves as feeling extremely positive about religion. In addition, as has been discussed in Chapter I, the sample was restricted to volunteers, and the particular characteristics of elderly volunteers are not known. Finally, the greatest threat to the validity of these results is the relatively small number of control participants. It is possible that

bereavement status might have been found to be a significant contributor to variances in depression scores and self-ratings of physical health if the control group had been larger. A larger, more heterogenous sample might have been more representative of elderly persons in this country, and allowed for broader generalizations of results. However, the intent of the broader scope of this research was to study a single religious group from rural communities.

Recommendations for Future Research

Because of the close relationship that was demonstrated to exist between level of grief and depression in the present sample, further investigation is recommended into the differences and similarities of these two variables. An item-analysis of the type performed by Gallagher et al. (1981) might be particularly useful for this.

In view of the present finding that a relationship exists between perceptions of physical health and depression, and the finding of Mossey and Shapiro (1982) that self-ratings of physical health can be used to predict future mortality, it is recommended that further investigation be conducted into the variables that influence such self-ratings.

It is recommended that an attempt be made to replicate the present finding of no relationship between grief and self-ratings of physical health, preferably with somewhat different type of sample (for example, with elderly urban residents).

In the present study bereavement status did not help to predict

the depression scores of elderly people. It is suggested that attempts be made to replicate this finding with other samples of elderly rural residents, to help determine if this is a characteristic of the rural elderly in general.

The close relationship between depression and self-ratings of physical health early in the mourning process bears further examination, possibly in conjunction with evaluation of social network variables pertaining to family and non-family important persons. If the change in focus that occured in the present study (with family members being more important early in bereavement, but friends and neighbors becoming more important several months later) can be replicated with other samples of elderly persons, a constructive step toward a more unified theory of stages of grieving may be achieved.

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APPENDIXES

Appendix A

Introductory Letter

UTAH STATE UNIVERSITY · LOGAN, UTAH

COLLEGE OF EDUCATION

DEPARTMENT OF
PSYCHOLOGY
UMC 28

Dear Friend:

All human beings suffer great losses. You have lost a loved one and we know that is always most difficult. We are studying what such a loss means so that we can make suggestions to those who might have similar losses. You can help us and many others by talking with us about your experiences. Our need is to talk with people over 55 who have lost a mate.

Those, like you, who suffer major losses go through very significant changes in life. If you could share with us what happened to you and how you felt, we will share our findings with others nationwide to help them better understand what happens at the time of death of a loved one.

If you agree to work with us, there are some steps we should take to make your contribution meaningful.

1. One of the members of our staff will contact you to answer any questions you might have and to give you more details about our project.

2. An appointment will be set up at a time convenient to you. The interviewers working with us have been specially selected and trained to conduct the interview in a highly professional manner. You may be visited at your home or you may come to the university for the interview. The length of the interview will vary. Every interview will be confidential. All interviews will be analyzed as a group, and we will share the final conclusions with you.

3. In addition, the university is providing individual and/or group counseling to help you if you desire that kind of help.

You will notice that we have enclosed a response card with this letter for your convenience. If you decide to participate in our project, fill out the card and mail it to us as soon as possible. We may also be calling you to discuss the possibility of your participation in this project. If you have any questions or wish more information about the project, please feel free to call us at: (801) 750-1457.

Thank you in advance for your time and interest.

Sincerely,

Michael R. Bertoch, Ed.D. Elwin C. Nielsen, Ph.D. JoAnn Johnson, M.Ed.

Bereavement Project Staff Associates

Appendix B

Reasons for Refusal to Participate

Reason Given	Group: Bereaved (n=223)	Group: Control (n=32)
Poor health	11.3%	2.5%
Too busy	10.4%	21.9%
Too old	3.2%	3.1%
Don't want to be bothered	24.4%	15.6%
Leaving area	3.2%	3.1%
Don't want to be interviewed (too private, too painful. too soon)	23.1%	9.4%
Too young	2.7%	3.1%
Not Mormon	.5%	0.0%
Other	0.0%	0.0%
(Indicated refusal by card or call, but gave no reason)	21.2%	28.2%
Percent	100.0%	100.0%

Appendix C

Instruments Used

1

T. I. G. (W)

SUBJ.#_____

INTERVIEW # _____

TOTAL PAST _____

TOTAL NOW _____

LOOKING BACK, I WOULD GUESS THAT MY RELATIONSHIP WITH MY SPOUSE WAS: (CIRCLE ONLY ONE)

1 ..CLOSER THAN ANY RELATIONSHIP I'VE EVER HAD BEFORE OR SINCE.

2...CLOSER THAN MOST RELATIONSHIPS I'VE HAD WITH OTHER PEOPLE.

3...ABOUT AS CLOSE AS MOST OF MY RELATIONSHIPS WITH OTHERS.

4...NOT AS CLOSE AS MOST OF MY RELATIONSHIPS.

5...NOT VERY CLOSE AT ALL.

PART 1. PAST BEHAVIOR

THINK BACK TO THE TIME RIGHT AFTER YOUR SPOUSE DIED AND ANSWER ALL OF THESE ITEMS ABOUT YOUR FEELINGS AND ACTIONS AT THAT TIME BY INDICATING WHETHER EACH ITEM IS COMPLETELY TRUE, MOSTLY TRUE, BOTH TRUE AND FALSE, MOSTLY FALSE, OR COMPLETELY FALSE AS IT APPLIED TO YOU THEN. CIRCLE THE BEST ANSWER.

	1= COMPL. TRUE	2= MOSTLY TRUE	3= TRUE & FALSE	4= MOSTLY FALSE	5= COMPL. FALSE
1. AFTER HE/SHE DIED I FOUND IT HARD TO GET ALONG WITH CERTAIN PEOPLE.	1	2	3	4	5
2. I FOUND IT HARD TO WORK WELL AFTER MY SPOUSE DIED.	1	2	3	4	5
3. AFTER MY SPOUSE'S DEATH I LOST INTEREST IN MY FAMILY, FRIENDS, AND OUTSIDE ACTIVITIES.	1	2	3	4	5
4. I FELT A NEED TO DO THINGS THAT THE DECEASED HAD WANTED TO DO.	1	2	3	4	5
5. I WAS UNUSUALLY IRRITABLE AFTER MY SPOUSE'S DEATH.	1	2	3	4	5
6. I COULDN'T KEEP UP WITH MY NORMAL ACTIVITIES AFTER MY SPOUSE'S DEATH.	1	2	3	4	5
7. I WAS ANGRY THAT HE/SHE LEFT ME.	1	2	3	4	5
8. I FOUND IT HARD TO SLEEP AFTER MY SPOUSE DIED.	1	2	3	4	5

OVER →

PART 2. PRESENT FEELINGS

NOW ANSWER ALL OF THE FOLLOWING ITEMS BY CIRCLING HOW YOU PRESENTLY FEEL ABOUT YOUR SPOUSE'S DEATH. PLEASE DO NOT LOOK BACK AT PART 1.

	1= COMPL. TRUE	2= MOSTLY TRUE	3= TRUE & FALSE	4= MOSTLY FALSE	5= COMPL. FALSE
1. I STILL CRY WHEN I THINK OF THE PERSON WHO DIED.	1	2	3	4	5
2. I STILL GET UPSET WHEN I THINK ABOUT MY WIFE (HUSBAND).	1	2	3	4	5
3. I CANNOT ACCEPT THIS PERSON'S DEATH.	1	2	3	4	5
4. SOMETIMES I VERY MUCH MISS MY SPOUSE.	1	2	3	4	5
5. EVEN NOW IT'S PAINFUL TO RECALL MEMORIES OF MY SPOUSE.	1	2	3	4	5
6. I AM PREOCCUPIED WITH THOUGHTS (OR OFTEN THINK) ABOUT HIM (HER).	1	2	3	4	5
7. I HIDE MY TEARS WHEN I THINK ABOUT HIM (HER).	1	2	3	4	5
8. NO ONE WILL EVER TAKE THE PLACE IN MY LIFE OF THIS SPOUSE.	1	2	3	4	5
9. I CAN'T AVOID THINKING ABOUT HIM (HER).	1	2	3	4	5
10. I FEEL IT'S UNFAIR THAT HE (SHE) DIED.	1	2	3	4	5
11. THINGS AND PEOPLE AROUND ME STILL REMIND ME OF MY SPOUSE.	1	2	3	4	5
12. I AM UNABLE TO ACCEPT THE DEATH OF MY SPOUSE.	1	2	3	4	5
13. AT TIMES I STILL FEEL THE NEED TO CRY FOR HIM (HER).	1	2	3	4	5

Subject # _____

Interview # _____

BECK INVENTORY TOTAL _____

INSTRUCTIONS: THIS QUESTIONNAIRE CONTAINS GROUPS OF STATEMENTS. PLEASE READ EACH GROUP OF STATEMENTS CAREFULLY. THEN PICK OUT THE ONE STATEMENT IN EACH GROUP WHICH BEST DESCRIBES THE WAY YOU HAVE BEEN FEELING DURING THE PAST WEEK, INCLUDING TODAY! CIRCLE THE NUMBER BESIDE THE STATEMENT YOU HAVE CHOSEN.

********** BE SURE TO READ ALL THE STATEMENTS IN EACH GROUP BEFORE MAKING YOUR CHOICE.

1.	0	I DO-NOT FEEL SAD.
	1	I FEEL SAD.
	2	I AM SAD ALL THE TIME AND I CAN'T SNAP OUT OF IT.
	3	I AM SO SAD OR UNHAPPY THAT I CAN'T STAND IT.
2.	0	I AM NOT PARTICULARLY DISCOURAGED ABOUT THE FUTURE.
	1	I FEEL DISCOURAGED ABOUT THE FUTURE.
	2	I FEEL I HAVE NOTHING TO LOOK FORWARD TO.
	3	I FEEL THE FUTURE IS HOPELESS AND THAT THINGS CANNOT IMPROVE.
3.	0	I DO NOT FEEL LIKE A FAILURE.
	1	I FEEL I HAVE FAILED MORE THAN THE AVERAGE PERSON.
	2	AS I LOOK BACK ON MY LIFE, ALL I CAN SEE IS A LOT OF FAILURE.
	3	I FEEL I AM A COMPLETE FAILURE AS A PERSON.
4.	0	I GET AS MUCH SATISFACTION OUT OF THINGS AS I USED TO.
	1	I DON'T ENJOY THINGS THE WAY I USED TO.
	2	I DON'T GET REAL SATISFACTION OUT OF ANYTHING ANYMORE.
	3	I AM DISSATISFIED OR BORED WITH EVERYTHING.
5.	0	I DON'T FEEL PARTICULARLY GUILTY.
	1	I FEEL GUILTY A GOOD PART OF THE TIME.
	2	I FEEL QUITE GUILTY MOST OF THE TIME.
	3	I FEEL GUILTY ALL OF THE TIME.

2

6.	0	I DON'T FEEL I AM BEING PUNISHED.
	1	I FEEL I MAY BE PUNISHED.
	2	I EXPECT TO BE PUNISHED.
	3	I FEEL I AM BEING PUNISHED.
7.	0	I DON'T FEEL DISAPPOINTED IN MYSELF.
	1	I AM DISAPPOINTED IN MYSELF.
	2	I AM DISGUSTED WITH MYSELF.
	3	I HATE MYSELF.
8.	0	I DON'T FEEL I AM ANY WORSE THAN ANYONE ELSE.
	1	I AM CRITICAL OF MYSELF FOR MY WEAKNESSES OR FAULTS.
	2	I BLAME MYSELF ALL THE TIME FOR MY FAULTS.
	3	I BLAME MYSELF FOR EVERYTHING BAD THAT HAPPENS.
9.	0	I DON'T HAVE THOUGHTS OF KILLING MYSELF.
	1	I HAVE THOUGHTS OF KILLING MYSELF, BUT I WOULD NOT CARRY THEM OUT.
	2	I WOULD LIKE TO KILL MYSELF.
	3	I WOULD KILL MYSELF IF I HAD THE CHANCE.
10.	0	I DON'T CRY ANY MORE THAN USUAL.
	1	I CRY MORE NOW THAN I USED TO.
	2	I CRY ALL THE TIME NOW.
	3	I USED TO BE ABLE TO CRY, BUT NOW I CAN'T CRY EVEN THOUGH I WANT TO.
11.	0	I AM NO MORE IRRITATED NOW THAN I EVER AM.
	1	I GET ANNOYED OR IRRITATED MORE EASILY THAN I USED TO.
	2	I FEEL IRRITATED ALL THE TIME NOW.
	3	I DON'T GET IRRITATED AT ALL BY THE THINGS THAT USED TO IRRITATE ME.

12.
0 I HAVE NOT LOST INTEREST IN OTHER PEOPLE.
1 I AM LESS INTERESTED IN OTHER PEOPLE THAN I USED TO BE.
2 I HAVE LOST MOST OF MY INTEREST IN OTHER PEOPLE.
3 I HAVE LOST ALL OF MY INTEREST IN OTHER PEOPLE.

13.
0 I MAKE DECISIONS ABOUT AS WELL AS I EVER COULD.
1 I PUT OFF MAKING DECISIONS MORE THAN I USED TO.
2 I HAVE GREATER DIFFICULTY IN MAKING DECISIONS THAN BEFORE.
3 I CAN'T MAKE DECISIONS AT ALL ANYMORE.

14.
0 I DON'T FEEL I LOOK WORSE THAN I USED TO.
1 I AM WORRIED THAT I AM LOOKING OLD OR UNATTRACTIVE.
2 I FEEL THAT THERE ARE PERMANENT CHANGES IN MY APPEARANCE THAT MAKE ME LOOK UNATTRACTIVE.
3 I BELIEVE THAT I LOOK UGLY.

15.
0 I CAN WORK ABOUT AS WELL AS I USED TO.
1 IT TAKES AN EXTRA EFFORT TO GET STARTED AT DOING SOMETHING.
2 I HAVE TO PUSH MYSELF VERY HARD TO DO ANYTHING.
3 I CAN'T DO ANY WORK AT ALL.

16.
0 I CAN SLEEP AS WELL AS USUAL.
1 I DON'T SLEEP AS WELL AS I USED TO.
2 I WAKE UP 1-2 HOURS EARLIER THAN USUAL AND FIND IT HARD TO GET BACK TO SLEEP.
3 I WAKE UP SEVERAL HOURS EARLIER THAN I USED TO AND CANNOT GET BACK TO SLEEP.

17.
0 I DON'T GET MORE TIRED THAN USUAL.
1 I GET TIRED MORE EASILY THAN I USED TO.
2 I GET TIRED FROM DOING ALMOST NOTHING.
3 I AM TOO TIRED TO DO ANYTHING.

18.

0 MY APPETITE IS NO WORSE THAN USUAL.

1 MY APPETITE IS NOT AS GOOD AS IT USED TO BE.

2 MY APPETITE IS MUCH WORSE NOW.

3 I HAVE NO APPETITIE AT ALL ANYMORE.

19.

0 I HAVEN'T LOST MUCH WEIGHT, IF ANY, LATELY.

1 I HAVE LOST MORE THAN 5 POUNDS.

2 I HAVE LOST MORE THAN 10 POUNDS.

3 I HAVE LOST MORE THAN 15 POUNDS.

20.

0 I AM NO MORE WORRIED ABOUT MY HEALTH THAN USUAL.

1 I AM WORRIED ABOUT PHYSICAL PROBLEMS SUCH AS ACHES AND PAINS OR UPSET STOMACH OR CONSTIPATION.

2 I AM VERY MUCH WORRIED ABOUT MY PHYSICAL PROBLEMS AND IT'S HARD TO THINK OF MUCH ELSE.

3 I AM SO WORRIED ABOUT MY PHYSICAL PROBLEMS THAT I CANNOT THINK ABOUT ANYTHING ELSE.

21.

0 I HAVE NOT NOTICED ANY RECENT CHANGE IN MY INTEREST IN SEX.

1 I AM MUCH LESS INTERESTED IN SEX THAN I USED TO BE.

2 I AM MUCH LESS INTERESTED IN SEX NOW.

3 I HAVE LOST INTEREST IN SEX COMPLETELY.

22. I AM PURPOSELY TRYING TO LOSE WEIGHT BY EATING LESS:

_____ YES ; _____ NO

3. Overall, how would you rate your health at this time? (USE PAGE 6 OF NOTEBOOK)

1	2	3	4	5	6	7
Very good			Average			Very poor

4. How does your health now compare to others your age? (USE PAGE 7 OF NOTEBOOK)

1	2	3	4	5	6	7
Much better			About the same			Much worse

5. How does your overall health now compare to before your husband's/wife's death? (USE PAGE 8 OF NOTEBOOK)

1	2	3	4	5	6	7
Much better			About the same			Much worse

6. How many times have you been to see the doctor since your husband's/wife's death?

0----NONE

RECORD NUMBER OF VISITS (1 OR MORE) _____

7. What were the reasons for these visits?
   1. _____
   2. _____
   3. _____
   4. _____
   5. _____

8. Have you been hospitalized since your husband's/wife's death?

2----NO

1----YES

9. What were the reasons for hospitalization?
   1. _____
   2. _____
   3. _____

10 A. Do you have any problems with your nerves -- like feeling down in the dumps all the time, feeling afraid something is going to happen to you, or other things like that?

2----NO

(GO TO #11)

1----YES

10B. When did these problems start? (Date)_____
(ONSET CODE FROM PAGE 6 - CODE AFTER INTERVIEW) ____

10C. How serious do you feel they are? (CIRCLE CODE)
1----Mild
2----Moderate
3----Severe

10D. Do you feel you need help?
1----Yes
2----No (GO TO #11)

14. I would like to know about the important people in your life NOW. Please identify several significant people and their relationship to you. For each individual, I would like to know how often you are in contact with them, either by letter, telephone or in person. I will also ask you to rate your feelings about each person and how much you confide in them. (OBTAIN ALL 3 RATINGS ON THE FIRST PERSON AND THEN ASK FOR ANOTHER IMPORTANT PERSON. CONTINUE THIS SEQUENCE UNTIL RESPONDENT FEELS HE/SHE HAS REPORTED ALL IMPORTANT PEOPLE. USE PAGE 40 OF NOTEBOOK)
Who is the most important person in your life at this time?

CODES FOR SOCIAL NETWORK:

Relationship

Child.....1
Parent.....2
Sibling.....3
Grandchild.....4
Aunt Uncle.....5
In-laws.....6
Other relative.....7
Close friend.....8
Other friend.....9
Clergy.....10
Physician.....11
Other.....12

Feelings

Very positive..... 1
2
3
Mainly neutral.....4
5
6
Very negative..... 7

Frequency

Every day..... 1
Several times a week..... 2
Once a week..... 3
Several times a month..... 4
Once a month..... 5
Once every two or three months.... 6
Less than every 2 or 3 months..... 7

Degree You Confide

Completely.....1
2
3
Somewhat.....4
5
6
Not at all.....7

AT THIS TIME

Relationship (Code)	Frequency	Feelings	Degree you Confide

VITA

JO ANNE P. JOHNSON

12021 Tall Oaks
Houston, Texas 77024

713-468-8691 (home)

EDUCATION:

Ph.D., Professional-Scientific Psychology (A.P.A. approved), with clinical emphasis, Utah State University, 1986.
M.Ed., Counseling and Guidance, Brigham Young University, 1981.
B.S., Child Development and Family Relations, Brigham Young University, 1978.
Paraprofessional Counselor Training Program, through Brigham Young University Counseling Center (as undergraduate).

INTERNSHIP:

9/84 to 12/85 Intern, Veterans Administration Medical Center
Houston, Texas

Trained in rotations focusing on family therapy, group treatment for alcoholics and psychiatric inpatients, individual therapy, personality and neuropsychological assessment, medical psychology (worked with cancer and kidney patients, ran weight-loss and relaxation groups), geriatric psychology, forensic assessment (for Harris County), and correctional psychology (at the Ellis II Unit of the Texas Department of Corrections.) The Houston V.A. Internship Program is A.P.A. approved.

WORK EXPERIENCE:

10/81 to 9/83 Research assistant, Utah State University.

The project focused on factors mitigating grief adjustment in elderly widows and widowers. Involvement included recruitment of bereaved and control subjects; coordinating interviews; training interviewers; scoring data; training and supervising activities of undergraduates working on the project for credit; and assisting in grant writing for additional funds to cover second year of research.

10/81 to 6/82 Counselor, Utah State University Counseling Center.

Did individual and marital counseling with students. Presenting problems included phobia, hair-pulling, school-related anxiety, fear of public speaking, binge-eating, diminished sexual response, and history of childhood abuse. Did career advisement using the Strong Campbell Interest Inventory. Used the Wais-R and MMPI in assessments.

5/82, 9/82 School Psychologist, Bureau of Indian Affairs
Navajo Reservation, Arizona

Performed psychological/educational evaluations on school-aged Navajo children with behavior problems and academic delays. Made oral and written reports of findings, with detailed recommendations for treatment.

8/81 to 10/81 Alcoholism counselor, Raleigh Hills Hospital
Salt Lake City, Utah

Led structured groups for patients and their families on dynamics of alcohol abuse. Acted as co-therapist in family therapy sessions.

10/78 to 8/81 Therapist, The Children's Behavior Therapy Unit
Salt Lake City, Utah

Designed, implemented and evaluated behavioral treatment programs for emotionally disturbed, conduct disordered and autistic children, ages seven to ten, in a self-contained classroom setting. Taught academic subjects. Led social skills training groups. Administered and interpreted results of academic tests including the AAMD/Adaptive Behavior Scale, the Walker Problem Behavior Checklist, the Woodcock Reading Mastery Test, the Keymath, and the Wide Range Achievement Test. Taught parenting skills individually and in structured groups. Kept progress notes.

2/78 to 8/78 Co-therapist, The Children's Center
Salt Lake City, Utah

Assisted in play therapy groups for emotionally disturbed and developmentally delayed preschoolers. Programmed activities.

9/76 to 7/77 Intake interviewer, Personal and Career Services
Brigham Young University
Provo, Utah

As a paraprofessional counselor, conducted private interviews with students to determine their particular needs, referring them to proper campus agencies or services ranging from vocational guidance to suicide prevention.

PRACTICA:

6/83 to 2/84 Therapist, Parents United
Logan, Utah

Led open group for adults who were victims of sexual abuse as children.

6/82 to 6/84 Therapist, The Community Clinic
Psychology Department
Utah State University, Logan, Utah

Treated clients of different ages in short- and long-term therapy, individually and in families. Presenting problems included divorce and step-family readjustment, incest, rape, smoking, personality and affective disorders.

11/82 to 7/83 Therapist, Bear River Community
Mental Health Center
Brigham City, Utah

Performed individual and family therapy, relaxation training with use of biofeedback. Served as co-leader of chronics group. Did psychological evaluations (including use of projectives) of children, adolescents and adults.

3/82 to 6/82 Psychologist, Exceptional Child Center
Utah State University

Assisted in history-taking, testing and report writing as part of an evaluation team, assessing the abilities and needs of developmentally delayed and behavior disordered children.

TEACHING:

9/83 to 6/84 Teaching assistant, Utah State University

Lectured, proctored and scored exams for a 5 credit hour course in introductory psychology.

Winter, 1983 Assertiveness training

Ran a half-day session for Native American high school students at the Intermountain Indian School, Brigham City, Utah.
Co-led a two day workshop for trainees in the Office Occupations Training Program on the U.S.U. Campus.